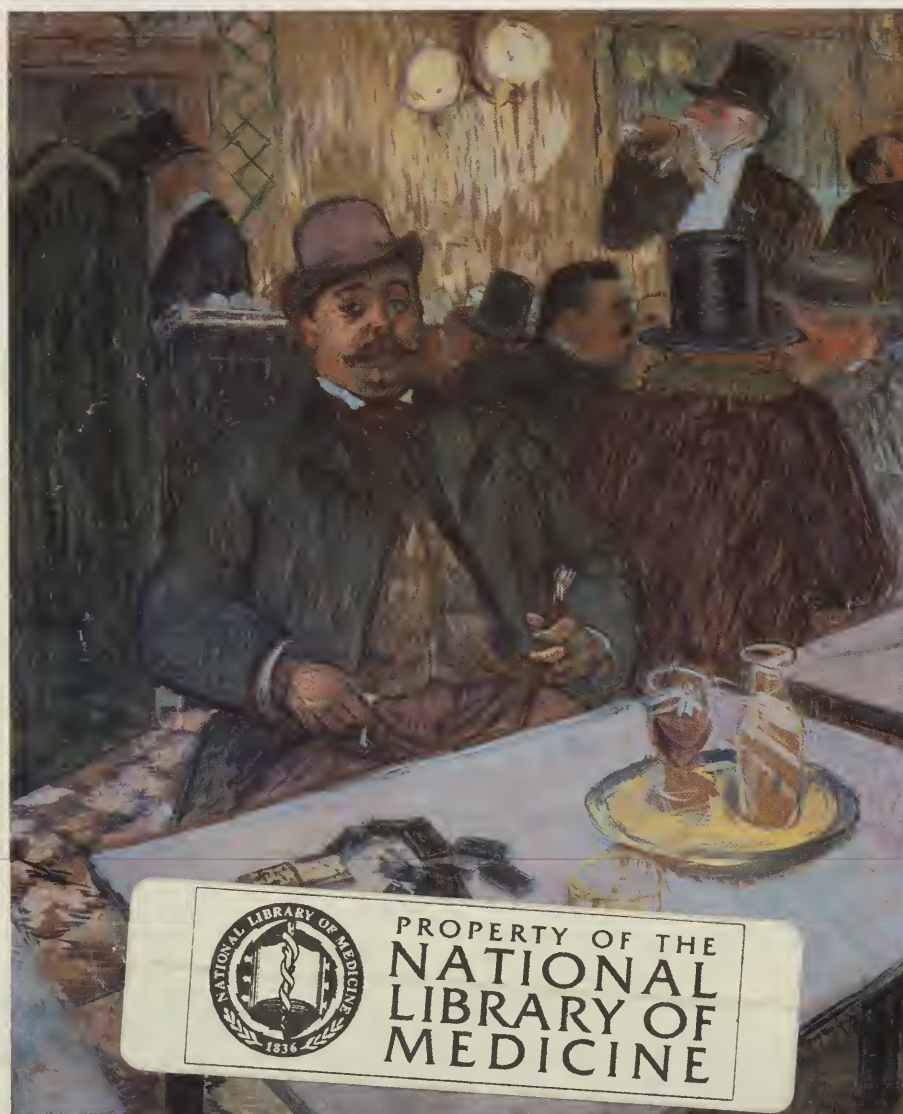


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Maryland Medical Journal
JANUARY 1994



Monsieur Boileau at the Café
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Alcohol and other drug abuse:
Physicians can make a difference

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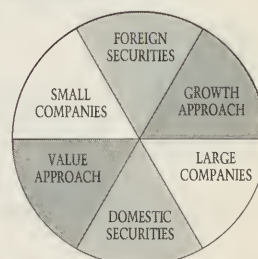
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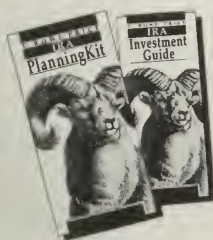
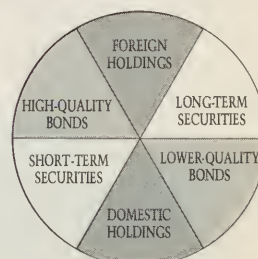
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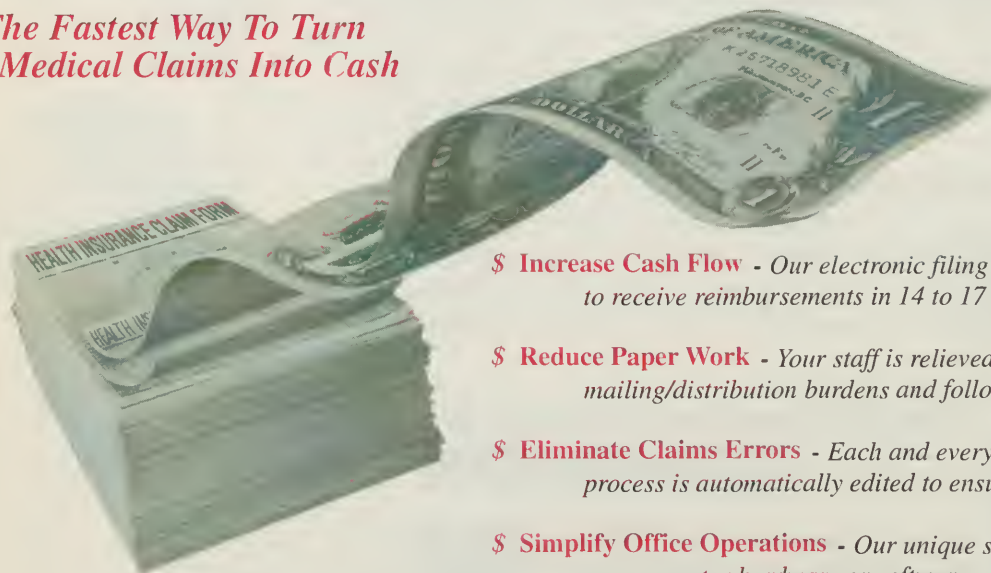
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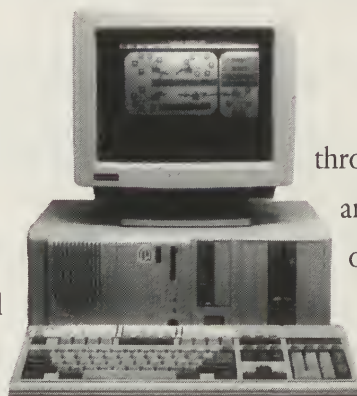
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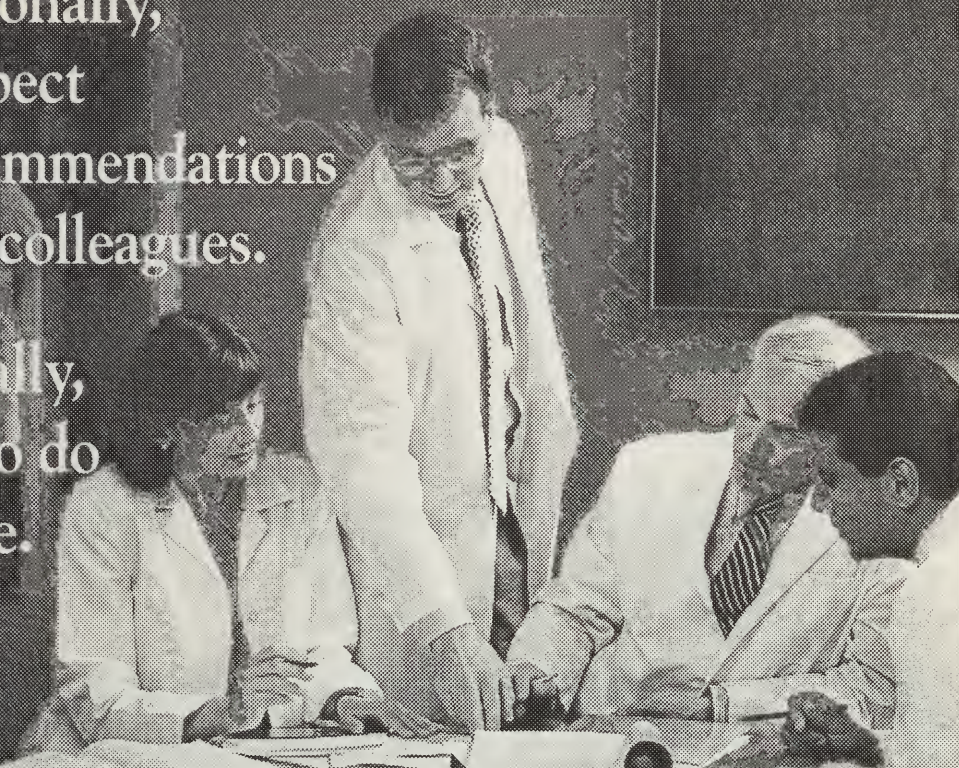
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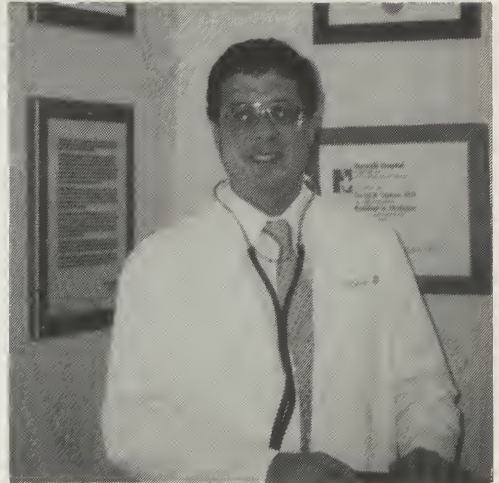


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- ▼ Montgomery County Medical Society (Board of Directors)
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Over 400 physicians have already contributed to Dr. Doman's campaign.

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Chief Executive Officer's Newsletter

January 1994

Annual Meeting Hotel Reservations

"Medicine Under Health System Reform—Impact on Patients and Physicians" is the theme for the 1994 Med Chi Annual Meeting being held Thursday, May 12 through Saturday, May 14, 1994, at the Ramada Inn and Convention Center, 901 Dual Highway, Hagerstown, Maryland. AMA President-elect Robert E. McAfee, M.D., will be the keynote speaker. A preliminary program and registration form will be mailed in February and will also be in the next issue of the *MMJ*. For room reservations at the Ramada, please call 301-733-5100 and indicate that you will be attending the Med Chi Annual Meeting. Room rates are \$57 for a single or a double. Reservations must be made by Friday, April 29, 1994.

Solicitation of BPQA Nominations

Pursuant to §14-202 of the Health Occupations Article of the *Annotated Code of Maryland*, all licensed physicians in Maryland wishing to nominate candidates for vacancies on the Board of Physician Quality Assurance may submit nominations, which must include a current CV, by February 18, 1994, to:

BPQA Vacancies
The Medical and Chirurgical Faculty of Maryland
1211 Cathedral Street
Baltimore, MD 21201

Persons making nominations must certify that the nominee is willing to serve and is a practicing licensed physician as required by §14-202.

Please note that the election to select the names of physicians to be submitted to the governor for possible nomination to the BPQA is **open to all licensed physicians in Maryland**. The election will be held on May 14, 1994, at the Ramada Inn and Convention Center in Hagerstown, Maryland. The time and place of balloting and a list of nominated candidates will be made available at a later date.

Flu Vaccine Update

Med Chi wrote to the Health Care Financing Administration (HCFA) expressing the concerns of its membership about the low payment for the flu vaccine. In a response to the correspondence, the HCFA regional administrator stated that while there continues to be review of the payments for the flu vaccine and its administration, no change has been made in the current amounts allowed for the vaccine. Therefore, Medicare is paying \$2.67 for administration of the vaccine (Q0124) and \$3.38 for the serum (90724). Med Chi will continue to pursue this issue with HCFA.

COLA Receives Deeming Authority

The Commission on Office Laboratory Accreditation (COLA) has officially received deeming authority from the Health Care Financing Administration (HCFA). COLA is the first major accrediting organization to obtain deeming authority under the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88) and the only accrediting organization for the office laboratory. This approval means that office laboratories accredited by COLA are "deemed" to meet the federal standards. Although COLA standards differ from the government's in several ways, laboratories accredited by COLA now meet all CLIA requirements including biennial inspection. In addition to fulfilling all CLIA requirements through COLA accreditation, COLA prepares the office laboratory by providing the physician the opportunity to conduct a comprehensive self-assessment. COLA's approach is educational. For more information concerning COLA, contact COLA at 301-588-5882.

Medicare Update

Effective January 1, 1994, Medicare coverage for medications is expanded to include oral cancer drugs. The medications are covered if they are the pill or oral form of drugs already supplied and administered in injectable form (e.g., if they have the same active ingredients as, and are used for the same indications as, the injectable or non-self-administrable forms). The medications must be approved by the Food and Drug Administration and be reasonable and necessary for the individual patient.

The 1993 Omnibus Budget Reconciliation Act (OBRA 1993) provides that there will be no Medicare update for inflation of ambulatory surgical center (ASC) facility rates in fiscal years 1994 and 1995. The wage index used to calculate payments to individual ASCs has been updated for services furnished on or after October 1, 1993.

Pennsylvania Blue Shield has published the "1994 Medicare Physician Fee Schedule Report for Montgomery and Prince George's counties" in its Medicare special notice dated November 22, 1993.

The Health Care Financing Administration (HCFA) has revised the list of surgical procedure codes that are eligible for assistant-at-surgery services. These revisions provide that no payment will be made for assistant-at-surgery for surgical procedures for which, on a national basis, an assistant surgeon was used in less than 5% of the cases. Prince George's County and Montgomery County physicians should note the Medicare special bulletin dated November 30, 1993, from Pennsylvania Blue Shield that indicates the procedure codes considered eligible for payment of assistant-at-surgery services. The bold underline codes that appear in the schedule require sufficient supporting documentation to establish medical necessity for an assistant-at-surgery.

Mental Health and Substance Abuse Benefits

President Clinton's plan would cover

Inpatient

- Thirty days maximum; extra 30 days when criteria are met
- Patient share: one-day deductible, 20% copayment, with \$1,500 annual maximum outlay (\$3,000 for family)

Intensive nonresidential

- One hundred and twenty days maximum
- Patient "buys" first 60 days by swapping one inpatient day for every two nonresidential days.
- Patient share: one-day deductible each service period, 20%-50% copayment, or \$25 per visit for enrollees of low-cost health plans

Outpatient

- Thirty psychotherapy visits
- Extra 120 visits at discretion of health plan; patient "buys" extra visits by swapping one inpatient day for every four outpatients visits
- Patient share: 50% copayment or \$25 per visit for enrollees of low-cost health plans

Substance-abuse relapse prevention

- Up to 30 group therapy visits within 12 months of intensive treatment

AM News, Dec. 27, 1993.

Senate Bill 389 - Mental Health Parity in Maryland

The mental health parity bill passed in 1993 goes into effect on the first renewal date on or after January 1, 1994, for insured or self-insured health plans in Maryland. This bill provides that mental health benefits must be provided on a non-discriminatory basis regardless of employer size. Health care programs may not

discriminate against any person by failing to provide benefits for mental illness on the same basis that is applied for other comparable health care benefits. However, an insurance participant may waive the increased mental health coverage provided as long as he or she does so on a form approved by the insurance commissioner.

Key Changes in the Clinton Health Plan

Medicare

- Balance billing eliminated.
- Fifteen percent withholding on physician pay for inpatient services at hospitals with high physician costs. Proportion of withholding returned to doctors depends on how the average medical staff charges per admission compare with targets.
- Competitive bidding for some services, including magnetic resonance imaging (MRI), computerized axial tomography (CT), oxygen, and lab.
- Income threshold lowered for wealthy seniors who will pay more for Medicare.

Health plans

- No limit on number of fee-for-service plans. Alliances may not declare fee-for-service plans not financially viable.
- All plans, including health maintenance organizations, must offer supplemental coverage for out-of-network providers, but premiums and copayments may be higher.
- Alliances not required to bar plans with premiums 20% above average.
- Somewhat easier for states to set up a single-payer plan.

Antitrust

- Provisions allowing physicians to collectively negotiate fee-for-service rates guaranteed in legislation, not left to regulators.

Physician supply

- Obstetrics and gynecology added to primary care. Primary care residency quota upped to 55% from 50%.
- National council, rather than regional councils, would recommend distribution of federally financed residency slots.

Nonphysician providers

- Model federal scope-of-practice law could preempt state laws.
- Advanced practice nurses may bill directly if working with physicians.

CLIA

- No certificates needed for waived tests, but no broad easing of regulations.

Quality

- Regional foundations dominated by academic health centers will run quality improvement programs. States cannot choose own models.
- Professional review organizations (PROs) will be dismantled.

National health board

- In executive branch, not independent.
- Practice of medicine now listed as an area of expertise that could qualify an individual to serve on the board.

Implementation date

- Universal coverage delayed one year to 1998.
- Long-term care, adult dental, and expansion of mental health benefits pushed back.

Subsidies

- Workers earning up to \$40,000 pay no more than 3.9% of income.
- Companies share cost of premiums for early retirees with government.

Entitlement cap

- Budget cap on federal subsidies for small businesses, low-wage workers, and early retirees. Could be loosened only by Congress.

AM News, Nov. 15, 1993.

Ten "Devilish Details" for Congress

At the American Medical Association (AMA) interim meeting in New Orleans, AMA Executive Vice President, James S. Todd, M.D., informed the House of Delegates that Congress needs "to work the devil out" of 10 AMA priorities to ensure meaningful health system reform.

The 10 devilish details Dr. Todd listed include

1. Avoid new bureaucracies that intrude on the traditional patient-physician relationship.
2. Give negotiating power to physicians.
3. Eliminate spending limits that limit care.
4. Keep medical decision making in physicians' hands, not in the hands of giant insurance companies.
5. Build national quality standards around medical, not economic issues.
6. Guarantee fee-for-service option for patients.
7. Take caution when deciding ratios of primary care physicians to specialists.
8. Simplify administrative hassles.
9. Reform medical liability laws to include caps on jury awards and lawyer fees.
10. Ensure universal access to care for all Americans.

AMA House of Delegates Approves Board's Policy-Making Powers

The AMA House of Delegates has empowered its Board of Trustees to independently make policy decisions during the periods between the interim and the annual meetings. The trustees must approve policy by two-thirds majority and bring it to a vote by the House. The new mandate, which was drafted by the Council on Long-Range Planning and Development, broadens the board's powers beyond health system reform to all "urgent situations."

Physician-Assisted Suicide

The AMA continues to oppose physician-assisted suicide. The AMA's Council on Ethical and Judicial Affairs (CEJA) noted that physicians are dedicated first and foremost to healing. The CEJA report urged physicians to employ pain control medications "to ensure that dying patients are provided optimal treatment and comfort."

Women's Health Initiative

The Women's Health Initiative's purpose is to investigate the impact of diet, hormones, and supplements on breast and colon cancer, cardiovascular disease, and osteoporosis. It is the largest US clinical trial ever and is being launched by the National Institutes of Health (NIH) to redress the historical absence of women's health research. The duration of the clinical trial is 14 years, and the projected cost is \$625 million. The study will include 160,000 women age 50-79.

For specific information concerning the study, please contact Women's Health Research, NIH, 926 Westwood Building, 5333 Westbard Avenue, Bethesda, MD 20892.

AMA National Leadership Conference

The AMA's 1994 National Leadership Conference is scheduled for February 11-13 in San Francisco, California. US Surgeon General Joycelyn Elders, M.D., accepted the AMA's invitation to speak at the conference. Conference participants will be joined by leaders from all areas of organized medicine and a variety of health care

organizations and will discuss critical political, economic, and social issues. Five general sessions are planned for the conference, and action-oriented breakout sessions will focus on prevalent public health problems, as well as specifics on state health reform and ethical issues confronting physicians.

For more information or to register, call 800-262-3211.

Electronic Claims EXPO

The Electronic Claims EXPO will be held on February 3, 1994, at the Sheraton Baltimore North, 903 Dulaney Valley Road, Towson. The expo provides a unique opportunity to learn about submission of electronic claims and to see area vendors. An electronic billing seminar will be held from 9:00 a.m. to 12:00 noon and will be repeated from 2:00 p.m. to 5:00 p.m. The vendor expo will be open from 9:00 a.m. to 7:00 p.m., and participants are encouraged to have lunch with the vendors from noon to 2:00 p.m. Concurrent workshops on ICD-9 coding, CPT coding, and how to avoid fraud and abuse will also be conducted. The cost to attend the electronic billing seminar is \$50 per person. There is no fee to attend the concurrent workshops or the lunch with the vendors, but preregistration is required.

This expo is sponsored by the Anne Arundel County Medical Society, Baltimore City Medical Society, Baltimore County Medical Association, Blue Cross and Blue Shield of Maryland Electronic Media Claims Division, and the Medical and Chirurgical Faculty of Maryland. For additional information or to register, call Teresa Adelman at 410-561-7964.

Med Chi Joins Sunday Rounds

Beginning January 16, 1994, Med Chi will move its radio program from WBAL to WBJC (91.5 FM). WBJC has a substantial listening audience throughout the state, including Prince George's and Montgomery counties. Med Chi will underwrite a one-hour program that will air live every other Sunday between 7:00 p.m. and 8:00 p.m. The program will use an audience call-in format with John Stupak serving as moderator. Physicians interested in participating in this program should call Heather Johnson at 410-539-0872 or 1-800-492-1056, ext. 306.

Physician Rehabilitation Program Featured on Straight Talk

Straight Talk, a half-hour show aired on Channel 45 at 12:00 p.m. every Friday, featured the Med Chi Physician Rehabilitation Program on January 28, 1994. The program will be made available to college cable stations for rebroadcast. Stanley R. Platman, M.D., chairperson, Med Chi Physician Rehabilitation Committee; Patricia McIntyre, M.D., member, Med Chi Physician Rehabilitation Committee; Craig Martin, M.D., Maryland Psychiatric Society; two anonymous recovering physicians; and Michael C. Llufrio, NCAC II, director, Med Chi Physician Rehabilitation Program appeared on the show. The show reviewed the current program, featured recovery stories, and highlighted the committee's work on the issue of sexual misconduct in a practitioner's office.

Medical Student Mentorship Program

The Maryland State Medical Student Association (Med Chi Student Component Society) and Med Chi are initiating a mentorship program for medical students. Med Chi physician members are asked to volunteer to have a medical school student accompany them for a day. This program will allow students the opportunity to view the demands, as well as the rewards, for the type of medicine they are considering. Physicians from all specialties are needed. The program will place interested physicians in touch with interested students, and scheduling will be conducted between the two parties at a time that is most convenient for them. Physicians and students interested in participating should contact Vivian Smith at 410-539-0872 or 1-800-492-1056, ext. 308.

Committee Selection Cards 1994-1995

Committee selection cards will be mailed in February to all Med Chi members. Members interested in serving on any Med Chi committee should complete the card and return it to Med Chi as soon as possible. If you have any questions about serving on a committee, please call Arlene Whalen at 410-539-0872 or 1-800-492-1056, ext. 307.

Future Semiannual Meeting Dates

The 1994 Med Chi Semiannual Meeting will be held at the Sheraton Resort and Conference Center in Ocean City, Maryland, Friday, September 9, 1994, through Sunday, September 11, 1994.

The 1995, 1996, and 1997 semiannual meetings have been tentatively scheduled at the Ocean City Sheraton on the following dates:

Friday, September 8 to Sunday, September 10, 1995

Friday, September 6 to Sunday, September 8, 1996

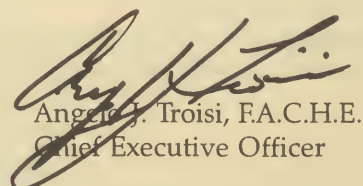
Friday, September 12 to Sunday, September 14, 1997

New Guidelines on HIV Released

New guidelines, *Early Evaluation and Management of HIV Infection*, were released by the US Public Health Service's Agency for Health Care Policy and Research to improve the ability of family doctors, pediatricians, and other front line primary care practitioners to provide critically important early care for persons recently infected with the human immunodeficiency virus (HIV). The guidelines include information on disclosure of HIV status, medical evaluation, and management, and include two accompanying booklets aimed at consumers. Copies of *Early Evaluation and Management of HIV Infection*, an accompanying quick reference guide, and the consumer booklets, may be obtained free, through a joint effort with the Centers for Disease Control and Prevention, by calling 1-800-342-2437 (AIDS), 1-800-344-7432 (SIDA) for those who speak Spanish, and 1-800-AIDS-TTY for the hearing impaired. The Med Chi library will also have several copies of the guidelines.

Study Group for Alternative Medicine

"Alternative Medicine in an Academic Health Care Setting" will be the topic of a talk by Brian Berman, M.D., at the second meeting of the Med Chi Study Group for Alternative Medicine. Dr. Berman is assistant professor of anesthesiology and family medicine at the University of Maryland Medical Center and director of the Laing-University of Maryland at Baltimore Complementary Medicine Project. The meeting, which was canceled in January due to inclement weather, will be held at Med Chi on March 9, 1994, at 7:30 p.m. Please call Steve Jones at Med Chi at 410-539-0872 or 800-492-1056, ext. 343, or Hiroshi Nakazawa, M.D., at 410-644-1502 if you wish to attend or receive additional information.



Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

PHYSICIAN REHABILITATION PROGRAM

The articles in this special edition of the *Maryland Medical Journal* deal with substance abuse in the general population. However, according to G. Douglas Talbott, M.D., a pioneer in the impaired physician movement, as many as 15% of physicians in any given state have or will have the disease of chemical dependency. An additional 5% will incur psychiatric illness. Since these figures are comparable with statistics for the general population, the following information is presented to help physicians recognize the symptoms of substance abuse in their colleagues and to familiarize physicians with the Med Chi Physician Rehabilitation Program.

Signs and symptoms of a problem

What should you consider when trying to decide if a physician friend or colleague has a problem and may be in need of help? Signs of a problem exist in virtually every area of the life of a physician addicted to alcohol or drugs, including social, work, and family settings. Physical health can also be affected. Outward signs include

IN THE COMMUNITY

- Isolation and withdrawal from community activities, hobbies, church, friends, and peers
- Embarrassing behavior at clubs or parties
- Drunk driving arrests or other legal problems
- Unreliability or unpredictability in social and community activities
- Unpredictable behavior; for example, inappropriate spending

IN THE HOSPITAL

- Making rounds late or at unusual hours
- Abnormal behavior during rounds
- Decreasing quality of performance
- Inappropriate orders or over-prescribing
- Reports of behavioral changes by staff
- Malpractice suits and legal sanctions
- Reports of unavailability or inappropriate responses to telephone calls

AT THE OFFICE

- Hostile, withdrawn, or other unreasonable behaviors
- Disruption of appointment schedule
- Inaccessibility to patients and staff
- Excessive ordering of drug supplies
- Patient complaints about doctor's behavior
- Frequent tardiness and unexplained absence

- Decreased work load or tolerance

IN THE HOME

- Behavior excused because of pressure of the profession
- Withdrawal from family activities
- Unexplained absences from home
- Arguments, fights, child abuse, or other violence
- Sexual problems—affairs, lack of interest, or impotence
- Assumption of surrogate role by spouse.
- Separation or divorce demanded by spouse
- Abnormal, antisocial, or illegal behavior by children

PHYSICAL SIGNS

- Deterioration in personal hygiene
- Deterioration in clothing and dressing habits
- Use of numerous prescriptions and drugs
- Complaints of various physical problems
- Frequent visits to physicians and dentists
- Frequent hospitalizations
- Multiple unexplained accidents
- Vague complaints about emotional state.
- Emotional crises

It is important to remember that a single symptom does not indicate impairment. One driving-while-intoxicated (DWI) offense does not mean someone is an alcoholic. However, multiple recurring serious life problems usually indicate some pathological process that requires treatment.

PHYSICIAN REHABILITATION PROGRAM

History of the program

To help physicians manage impairing illnesses, Med Chi formed the Committee on Physician Rehabilitation in 1977, which oversees the Physician Rehabilitation Program. The program's charter planners included Drs. Joseph Berman, Maxwell Weisman, Charles Bagley, Joseph Chambers, and James Davis. The committee's first chairperson was Jerome J. Collier, M.D., a former chairperson of the Commission on Medical Discipline. Dr. Collier thought that impaired physicians should be given an opportunity for treatment rather than simply lose their medical licenses in Maryland.

The Physician Rehabilitation Program helps physicians dealing with alcoholism, drug abuse, psychiatric illness, organic impairments, marital or family conflicts, and physical handicaps. The program's mission is to identify impaired physicians, assess and refer them to appropriate treatment, and then support and monitor their recovery. Physicians in the program go through evaluation and treatment and then are placed under contract for monitoring over a five-year period. Ongoing progress is documented to verify that the physician remains in stable recovery and can practice medicine safely. The program is available to all Maryland physicians and their families, and its services have an impact on the health of thousands of citizens across the state.

The program has significantly increased its outreach efforts over the last three years and is now recognized by state health care advocates as the primary resource for impaired physicians. The program's committee members and staff have developed a very positive working relationship with the state Board of Physician Quality Assurance (BPQA) with which they have developed memoranda of understanding and disposition agreements. This strong relationship also facilitates the BPQA's confidential referral of physicians to the program for assessment, evaluation, treatment, and monitoring.

The Physician Rehabilitation Program includes the Focused Professional Education Program, which evaluates the competency of physicians and then designs a specific curriculum to correct any identified deficiencies. The Physician Rehabilitation Program also provides educational experiences for physicians via seminars and conferences. The program's first three annual conferences were attended by almost 600 health care professionals.

In addition to its primary functions, the program assists hospitals and health care organizations with physician impairment issues and general counseling problems. The program's staff offer referral guidance to physicians who have patients with addiction and other mental health problems.

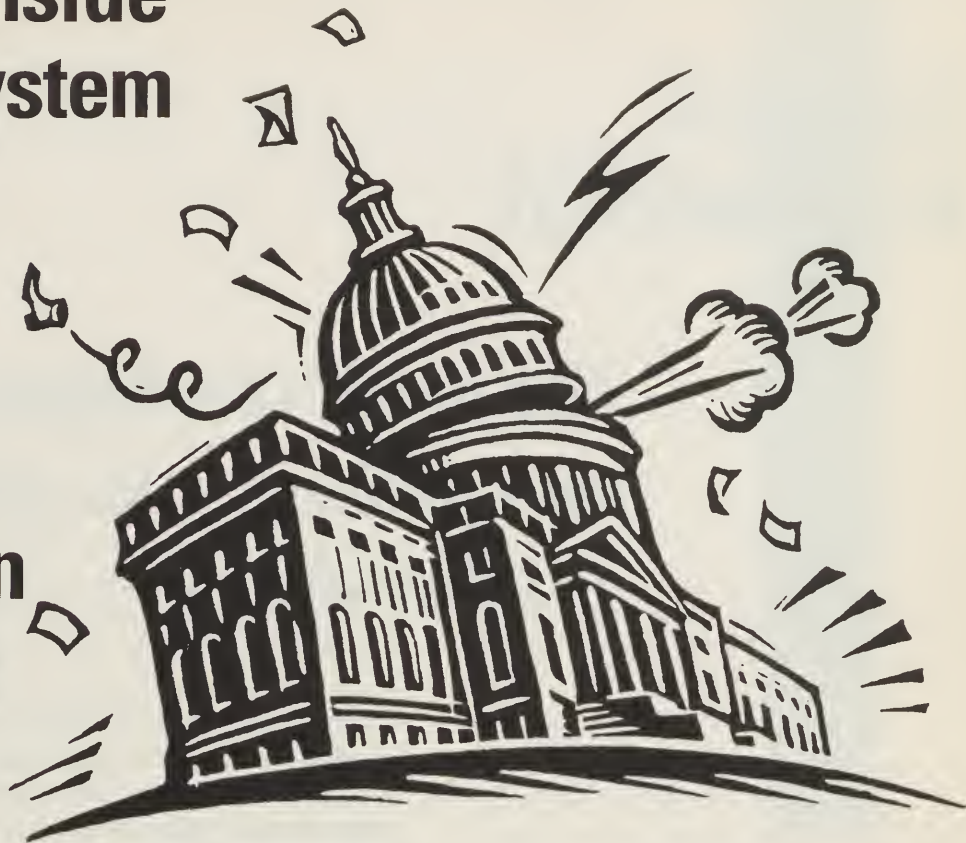
The Physician Rehabilitation Program also disseminates information about the inappropriateness of physician-patient sexual contact. Its pamphlet, developed with the Maryland Psychiatric Society, *MEDICAL TREATMENT NEVER INCLUDES SEXUAL CONTACT*, has been printed in *Straight Forward* and will be sent to every physician in Maryland.

The Physician Rehabilitation Program is among the finest of its kind in the country and is dedicated to providing much needed services to the physicians of Maryland. Recently, the program has begun dealing with other physician wellness issues, including how to achieve a balanced life. This program evolved from efforts to assist physicians with stress-related problems, particularly the stress resulting from malpractice litigation.

If you have concerns about a physician, contact the Physician Rehabilitation Program of the Medical and Chirurgical Faculty at 410-962-5580 or toll-free, 800-992-7010.

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The art of communicating with patients who use alcohol or other drugs

In this highly technical era on the brink of the 21st century, the achievements of medical science are quite astounding. Not only is the transplantation of human body parts possible, but the fields of genetic engineering and robotics promise even more radical modifications of human anatomy and physiology. Unfortunately, with so much attention focused on the science of medicine, there is often an attendant neglect of the art of medicine. Nowhere is this clearer than in the area of interpersonal communication.

Like it or not, many physicians have poor communication skills. Consequently, not only do many patients not understand their doctors, some do not even like their doctors. It is this writer's opinion that such communication problems may be part of the reason for the large amount of litigation directed toward physicians. Let us not forget that patients are people, and people like to be treated as individuals. Physicians who behave strictly as cold, detached scientists may strike their patients as automatons attempting to relate to other automatons.

Interpersonal communication deficiencies prevail in the field of medicine because the art of communication is not properly valued. Individuals who are allowed into the field may have good technical knowledge but underdeveloped interpersonal skills. Medical training then builds upon the technical knowledge base, but does not enhance interpersonal sensitivity and relationship skills.

Accordingly, Bernie Siegel, Yale surgeon and author of *Love, Medicine, and Miracles*, has proposed that medical training include a segment during which medical students go through the experience of being hospitalized patients.¹ The effect of such a strategy is illustrated quite vividly in the popular movie, *The Doctor*. As the film opens, the protagonist of the story, portrayed by William Hurt, is a heartless, crass surgeon who is unconcerned with people's feelings. As the story progresses, the surgeon is diagnosed with, and treated for, cancer. By the end of the film, the viewer discovers a transformed physician—one who understands his patients because he has been a patient and can teach his students with knowledge of, and sensitivity

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to, the patient's perspective. Siegel and others like him believe medicine should attune itself to psychological as well as material factors. That is to say, the art of medicine must be given the same consideration as the science of medicine.

Certain circumstances provide graphic examples of the significance of effective communication. If, for example, a physician and patient do not speak the same language, then effective diagnosis and treatment can become extremely difficult. Similarly, if the patient and physician derive from strikingly divergent cultures, they discover that words and images have different meanings even though they may speak the same language. There are other instances, however, in which communication differences may be less apparent. Communication between physicians and substance abusers is a case in point.

Underdetection of substance abuse by primary care health providers is an established fact.²⁻⁴ One reason for this underdetection is faulty communication between physicians and patients. Faulty communication can present itself under many guises: physicians may stereotype substance abusers or communicate judgmental, disrespectful attitudes toward their substance-abusing patients, and patients typically cover-up, deny, or underreport their use of various substances.

Patients communicate with physicians by what they say, as well as by the way they speak and dress, and by their general demeanor. When physicians use these communications to classify patients into various categories, they begin to stereotype. Thus, the typical alcoholic individual is stereotyped as a skid row bum, and the typical drug-addicted person is thought of as an African-American dropout who shoots up heroin and snatches purses from little old ladies in order to feed his habit. In actuality, alcoholic individuals range from teenaged high school students to senior executives, both male and female. Those addicted to drugs are school teachers and lawyers and housewives and retirees. Substance abusers come in all shades, from all races and ethnic groups, and can be of any age. They may wear Adidas tennis shoes or Pierre Cardin suits. They may be poor or wealthy.

It is critical that physicians eradicate their stereotypical images of substance abusers in order to be sufficiently open-minded to detect substance abuse in cases where it might not traditionally be suspected. Otherwise, clinicians may overscreen individuals who match a stereotype and underscreen those who do not fit the mold.

Once physicians have cleared their minds of stereotypical images, it is helpful to understand certain psychological aspects of substance abusers. Clinicians should be aware of the basic reason a person uses alcohol or drugs (i.e., to increase pleasure or decrease pain). For the substance abuser, the

Guest Editorial

pattern of usage takes on a compelling edge: the substance abuser not only feels, "I want to do this," but also, "I **must** do this." In the absence of the substance, the individual thinks about the drink or drug and craves it, and then takes action to fulfill the craving—to achieve a "high." After the high, the individual may feel shame or guilt and seek to hide the problem. He or she may deny that the usage is a problem, making false claims of control such as, "I can quit whenever I want to." Various authors have discussed interview and communication strategies to deal with these tendencies to cover-up, deny, and downplay substance abuse.^{5,6}

To help substance abusers, physicians should build doctor-patient relationships in which patients feel comfortable discussing their most private affairs. Assuring patients that confidentiality will be maintained can facilitate disclosure (e.g., "This is your safe place to talk about **anything** that affects your health."). Additionally, clinicians should not respond judgmentally about whatever their patients reveal and should be respectful, rather than condescending (e.g., "Nothing will be held against you here, regardless of what you say.")

Physicians should be frank in asking about patients' use of alcohol and other drugs. Any clinical or laboratory findings should be gently pointed out as manifestations of the drinking or drug problem. Effective physicians use firm guidance and sympathetic understanding in formulating treatment plans and in referring patients to resources. Clear directions ("Here is the telephone number of Dr. Smith, who specializes in your type of illness. With your permission, I'll give her a call and tell her she will be hearing from you.") are preferable to vague suggestions ("Have you ever thought of going to Alcoholics Anonymous?").

Educational resources can also be recommended. For literate patients, *High on Life* is a good publication.⁷ The set of booklets, *Freedom from Alcohol and Tranquilizers*, is another good educational resource, as is *The Miracle of Recovery*.^{8,9} Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have a variety of printed materials.

Once a treatment course has been plotted, patient follow-up can demonstrate a caring attitude. Follow-up can be carried out by telephone ("Hello, I'm calling to see if you have seen Dr. Smith yet.") and on return visits ("Is your usage of [substance] the same or different? What did you do to make such changes?").

The perspective and approach presented here for working with persons who use alcohol or other drugs is based on medicine as an art and not only as a science. The art of medicine requires sensitivity, rhythm, and timing. Artful physicians listen attentively and speak with discretion, attuned to individuals and the situation. Artful physicians communicate in such a way

Guest Editorial

that patients sense an intimate connection and, therefore, can say, "My doctor really cares about me." This connection can be reassuring as well as therapeutic for the substance abuser.

References

1. Siegel B. *Love, Medicine, and Miracles*. New York: Harper and Row. 1988.
2. Cleary PD, Miller M, Bush BT, Warburg MM, Delbanco TL, Aronson MD. Prevalence and recognition of alcohol abuse in a primary care population. *Am J Med* 1988; 85:466-71.
3. Coulehan JL, Zettler-Segal M, Block M, McClelland M, Schulberg HC. Recognition of alcoholism and substance abuse in primary care patients. *Arch Intern Med* 1987; 147:349-52.
4. Kamerow DB, Pincus HA, MacDonald DI. Alcohol abuse, other drug abuse, and mental disorders in medical practice. Prevalence, costs, recognition, and treatment. *JAMA* 1986; 255:2054-57.
5. Bird B. *Talking with Patients*. Philadelphia: J.B. Lippincott. 1993.
6. MacKinnon R, Michels R. *The Psychiatric Interview in Clinical Practice*. Philadelphia: W.B. Saunders. 1971.
7. Silverstein LM, Edelwich J, Flanagan D. *High on Life*. Hollywood, Florida: Health Communications, Inc. 1981.
8. Maultsby M. *Freedom from Alcohol and Tranquilizers*. Lexington, Kentucky: Rational Self-Help Books. 1979.
9. Wegscheider-Cruse S. *The Miracle of Recovery*. Deerfield Beach, Florida: Health Communications, Inc. 1989. ■

MAXIE T. COLLIER, M.D.

Dr. Collier is clinical assistant professor, Department of Psychiatry, the Johns Hopkins University and the University of Maryland.

Share your opinions

The Editorial Board of the *Maryland Medical Journal* encourages Med Chi members to share their opinions, beliefs, and convictions about all aspects of medicine. Letters to the Editor and essays for *Speak Out* should be sent to Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, MD 21201-5585.

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BSAS commends *MMJ* initiative

Baltimore Substance Abuse Systems, Inc. (BSAS) is pleased with Med Chi's decision to devote an issue of the *Maryland Medical Journal* to substance abuse. The impact of alcohol and drug abuse pervades our society, yet there is still much that is misunderstood regarding this disease. It is our hope that as the articles are read and discussed among those in the medical profession and others in the community, that many will gain new insight into the disease, its symptoms, and treatment.

The demand for substance abuse treatment continues to grow at a faster rate than the required resources. Consequently, new strategies are needed

to maximize available dollars and to attract additional resources. This special edition of the journal provides a framework for discussions among health care professionals that may lead to creative methods for addressing the needs.

We wish Med Chi much success with its substance abuse edition of the journal. We trust that it will serve not only as a source of pertinent information, but also as a source of motivation for substance abuse treatment improvement. Your initiative is congratulated and truly welcomed. ■

THOMAS DAVIS

Mr. Davis is acting executive director of Baltimore Substance Abuse Systems, Inc.

Partnership helps identify substance abusers

It is not an exaggeration to say that primary care physicians play an increasingly important role in providing and maintaining the health of their patients. Today's primary care physician is not only responsible for a patient's health, but, in many instances, also acts as counselor, friend, and confessor. While the additional roles may complicate the physician's function, these roles frequently serve to provide more insight into the health of the patient and his or her family as well. While it is not unusual for a family member to recognize another member's substance abuse problem, it is often the primary care physician who is asked to confront the person with the problem and make suggestions for appropriate action and treatment.

The Governor's Drug and Alcohol Abuse Commission is pleased to see this *Maryland Medical Journal* dedicated to substance abuse. The more we understand the problem, the better able we will be to treat it. The partnership between the commission and Med Chi in a program that teaches primary care physicians what to look for and how to approach the substance-abusing patient is an important link in the assessment, referral, and treatment chain. Such partnerships are essential if we are to continue our work to identify and treat substance abusers. ■

FLOYD O. POND

Mr. Pond is executive director of the Governor's Drug and Alcohol Abuse Commission

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Physicians can make a difference

Carmine M. Valente, Ph.D., and Karen R. Duszynski

Dr. Valente, who serves as project director for Med Chi's substance abuse education program for primary care physicians, and Ms. Duszynski, project coordinator, were guest editors for this issue of the *Maryland Medical Journal*.

IN 1991, THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND (MED CHI) surveyed physicians in selected Maryland counties regarding their practice patterns in treating substance-abusing patients. Survey results revealed that physician confidence in screening and counseling for substance abuse was low and that only 40% of the physicians routinely screened patients for alcohol abuse, while only 20% screened for other drug abuse. As a group, these physicians clearly felt the need for more education in substance abuse since they recommended many more hours of substance abuse education in both medical school and residency training than they themselves had received.

As a result of this survey, Med Chi began developing a substance abuse education program for primary care physicians. With funding from Baltimore Substance Abuse Systems, Inc. (BSAS), Med Chi designed a continuing medical education curriculum that provides an overview of treating the substance-abusing patient. The curriculum was presented in Baltimore in 1992 and 1993 and, under the auspices of the Governor's Commission on Drug and Alcohol Abuse, is now being offered on a statewide basis.

Med Chi is pleased to present this special issue of the *Maryland Medical Journal*, which complements and extends Med Chi's efforts to educate physicians about substance abuse topics. A constant theme in this issue is the importance of screening **all** patients for substance abuse, not just those who fit a preconceived image of an alcohol or drug abuser. Who would guess that the cover artist, a wealthy member of the French aristocracy, was also a chronic alcoholic individual who died at the age of 36? As an alcoholic artist, Henri de Toulouse-Lautrec joins a long line of gifted individuals who also happened to be substance abusers, including: Charles Baudelaire, Samuel Taylor Coleridge, Miles Davis, William Faulkner, F. Scott Fitzgerald, Betty Ford, Paul Gauguin, Ulysses S. Grant, William Stewart Halsted, Ernest Hemingway, Billie Holiday, James Joyce, Sinclair Lewis, Jack London, Modeste Mussorgsky, Edgar Allan Poe, Arthur Rimbaud, Dylan Thomas, Vincent van Gogh, Paul Verlaine, and Tennessee Williams.

A close look at the cover portrait reveals that its subject is drinking absinthe, a type of liqueur widely abused in the late 19th century. Med Chi's historian, Margaret Burri, M.A., opens the issue with a discussion of the cover portrait and absinthe. Maxie T. Collier, M.D., then presents a guest editorial on the art of communicating with patients who use alcohol or other drugs.

The lead article by Jo DeWeese, Ph.D., provides an overview of the alcohol and drug abuse problem in Maryland. While the statistics are daunting, Dr. DeWeese points out that physicians are in a key position to intervene in the process of substance use and abuse, and that such physician intervention has been shown to be effective in reducing levels of substance abuse. She concludes her article with specific steps Maryland physicians can take to enhance their involvement in caring for substance-abusing patients.

The next two articles deal with screening and assessment. Richard W. Moore, M.D., reviews several screening questionnaires, and John R. Steinberg, M.D., provides details on how to obtain and evaluate the pertinent laboratory, physical, and historical information associated with various types of drug and alcohol abuse.

The remaining articles focus on substance abuse treatment. David N. Nurco, D.S.W., and his colleagues tackle the topic of treatment effectiveness. They present findings indicating "that methadone maintenance, therapeutic communities, and outpatient drug-free treatment are generally effective in reducing illicit narcotic use and the criminal activity that often accompanies narcotic addiction." Barton A. Harris, M.D., provides guidelines to help physicians choose the most appropriate treatment for a given patient. Kevin Scott Ferentz, M.D., and Carmine M. Valente, Ph.D., address Maryland's number one substance abuse problem in the next article, where they present simple techniques physicians can use to help patients stop smoking. The concluding article by Burton C. D'Lugoff, M.D., lists treatment resources to which Maryland physicians can refer their substance-abusing patients.

The guest editors would like to thank the authors for their contributions; Baltimore Substance Abuse Systems, Inc. and the Governor's Commission on Drug and Alcohol Abuse for their support of this project; the recovering addicts who were generous enough to share their stories with us; Med Chi's Physician Rehabilitation Program; and members of Baltimore's substance abuse treatment system whose assistance and advice have contributed to the success of Med Chi's substance abuse education program. ■

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Absinthe, Toulouse-Lautrec, and *l'heure verte*

Margaret Burri, M.A.

Ms. Burri is administrator/historian of the Med Chi library.

IN THE LATE 19TH CENTURY, PARISIANS OF ALL CLASSES CELEBRATED *L'HEURE verte* with a glass of absinthe. The liqueur's green color gave the cocktail hour its name. The ritual of absinthe drinking involved suspending a sugar cube on a spoon over the glass. Cold water poured over the sugar sweetened the bitter beverage and gave it a milky opalescence. To many, absinthe drinking seemed a harmless enough pastime. After all, the liqueur contained ingredients long touted for their medicinal properties—fennel, melissa, and wormwood.¹ Wormwood, for example, to ward off fevers, was issued to French soldiers fighting in Algeria in the 1840s. The soldiers spiked their wine with it, and after returning to France, they satisfied their taste with absinthe.¹

The ex-soldiers were joined by people from all walks of life. Artists and writers in particular favored absinthe, believing that it evoked new views and experiences. Henri de Toulouse-Lautrec, who painted this month's cover image, *Monsieur Boileau at the Café*, in 1893, was an avid absinthe drinker. He kept the liqueur in a hollow cane as he prowled the seedy dance halls.

Lautrec's father, the Comte Alphonse de Toulouse-Lautrec, disapproved of his son's lifestyle. Perhaps in response to this, Lautrec included his father in the background of *Monsieur Boileau*. Although not indulging in absinthe like the monsieur, the white-bearded, top-hatted Comte is clearly enjoying the café life.²

Lautrec's addiction led to hallucinations and amnesia—symptoms commonly associated with “absinthism.” In March 1899, after a violent attack of delirium tremens, Lautrec's parents had him kidnapped and committed to a sanitarium. Although he was careful about his habits after that, his health deteriorated, and he died in 1901 at the age of 37.

Although absinthe had gained widespread acceptance by the 1890s, warnings about its effects appeared as early as the 1850s. In 1859, for example, Auguste Motet wrote his thesis for his medical degree on absinthe: “On Alcoholism and the Poisonous Effects Produced in Man by the Liqueur Absinthe.”¹ The active ingredient commonly thought to be responsible for the dangers of absinthe is thujone, a dicyclic ketone. Found primarily in wormwood, thujone causes hallucinations, convulsions, and permanent damage to the nervous system. Medical investigators recommended banning absinthe, but the profits made on the liqueur by both manufacturers and the state delayed its outlawing until the 20th century.³ No individual alcoholic drink except absinthe has ever been singled out for prohibition.

In the late 1980s, several French politicians began lobbying for the repeal of the ban. Fearing that Spain, which had never outlawed absinthe, would begin to sell it to other countries when it became a full member of the EEC (European Economic Community) in 1992, French officials wanted to share in the profits. The ban, however, was not lifted, and Spain did not export the liqueur; absinthe is still available on a bootleg basis in parts of Switzerland.²

As absinthe's history shows, substance abuse affects those in all walks of life. Seduced by its mystique and held enthralled by its chemical composition, absinthe drinkers met warnings about the liqueur with skepticism. Government intervention finally led to its downfall. Yet, less than 100 years after Lautrec's death, some are calling for legalization of absinthe and questioning the toxicity of thujone.²

References

1. Arnold WN. Absinthe. *Sci Am* 1989; June:112-17.
2. Conrad B. *Absinthe: History in a Bottle* Chronicle Books: San Francisco: 1988.
3. Arnold WN, Loftus LS, Conan PA. A search for Santoni in *Artemisia pontica*, the other wormwood of old absinthe. *Journal of Chemical Education* 68:27-28. ■

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Substance abuse in Maryland: what physicians can do to help

Jo DeWeese, Ph.D.

*Dr. DeWeese is former executive
director of Baltimore Substance
Abuse Systems, Inc.*

ABSTRACT: *Based on national prevalence studies and Maryland data, one out of 2 adults has used alcohol in the past month, one out of 4 has used cigarettes, and one out of 16 has used one or more illicit drugs. Annual prevalence rates are considerably higher, as are current rates for certain subgroups, including unemployed persons, young adults, certain racial and ethnic minorities, residents of metropolitan areas, men, and women in their childbearing years. Ten percent of persons age 12 or over need treatment for substance abuse, but less than one quarter of those receive it. Physician interventions with patients who are substance abusers have been shown to be effective, but physicians frequently do not detect their patients' alcohol or other drug abuse. Suggestions are offered to help physicians improve their ability to identify and treat or to refer patients with substance abuse problems.*

Baldwin et al¹ recently examined the total contribution of tobacco, alcohol, and illegal drugs to costs at the Johns Hopkins Hospital. They reported that 28% of all admissions to the adult intensive care unit and more than a third of the resulting medical costs were related to substance abuse. Tobacco accounted for 14% of the admissions and 16% of costs; alcohol accounted for 9% of patient stays and 13% of costs; and illegal drugs were responsible for 5% of admissions and 10% of costs. Substance abuse is a major problem in Maryland from both an economic and a medical standpoint, and primary care physicians are in a unique position to help reduce the levels of substance abuse in their patients.

Physicians can expect to see a number of substance-abusing patients each day, since substance abusers are generally overrepresented in patient populations.^{2,3} It is estimated that more than half of those with substance abuse disorders are never seen by a specialist, but obtain all their care from

the general medical sector.⁴ Primary care physicians, who see patients on a regular, long-term basis, have the opportunity to identify substance-abusing patients and recognize problems early in the addiction process when treatment may be most successful.

Studies have shown, however, that physicians frequently do not detect substance abuse in their patients.⁵⁻⁷ This failure to diagnose substance abuse is due largely to a failure to screen effectively. In a 1991 survey,⁸ the Medical and Chirurgical Faculty of Maryland (Med Chi) found that only 40% of primary care physicians in the Baltimore and Cumberland areas routinely screened for alcohol abuse and only 20% screened for other drug abuse.⁹

In a study at the Johns Hopkins Hospital,¹⁰ the prevalence of alcoholism was determined by a comprehensive assessment of new admissions to adult inpatient services. While prevalence ranged from 13% in obstetrics/gynecology to 30% in psychiatry, detection rates by physicians were not encouraging. Less than 10% of alcoholic patients were correctly identified by gynecologists, and only 25% to 50% were identified by internists and neurologists.

Physicians' inability to detect substance abuse or reluctance to diagnose these conditions is of special concern, since even physician interventions that involve limited time and resources (such as providing information, encouragement, brief counseling, or advice) have been shown to be effective in reducing levels of substance abuse.¹¹⁻¹³ Walsh et al¹³ followed 200 workers who were documented to have been consuming large amounts of alcohol and who had been referred by their employers to an employee assistance program. While most of these workers had seen a physician at least once in the prior year, only 22% had been advised by their physicians to modify their drinking habits. Those who had received such advice, however, were significantly more likely to be abstaining and sober two years later and were less impaired.

There are a number of reasons why physicians are not identifying and treating substance abuse. The *1991 Policy Report of the Physician Consortium on Substance Abuse Education*¹⁴ found that (1) "alcohol and other drug abuse education is not an integral part of primary medical education," and (2) "the traditional emphasis on hospital-based technologically complex diagnosis and treatment, on organ pathology, and on a cure-oriented approach to acute illness is ill-suited to dealing with chronic behavioral pathology that antedates the development of organ pathology in alcohol or drug abusers." In addition to these educational failures, the consortium itemized other factors that contribute to ambivalence about substance abuse and feelings of inadequacy in dealing with such problems. These include "negative attitudes and prejudices concerning alcohol and drug abusers," "skepticism regarding treatment effectiveness," and "deficiencies in the treatment reimbursement system."

Another issue complicating physician involvement in identifying and treating substance abusers is the mutable nature of substance abuse. New drug forms, analogs, or combinations emerge sporadically and may be used by different subpopulations or in specific geographic locations. The signs, symptoms, and consequences of substance abuse are dependent on the particular drug(s) used, the modes of use, and the frequency, intensity, duration, and legality of use. Identification of substance abusers can be facilitated by knowledge of which population subgroups are at greatest risk of using drugs and the current patterns and medical consequences of substance abuse.

Scope of the substance abuse problem in Maryland

Data sources. Physicians interested in keeping abreast of local substance abuse trends have a number of data sources available to them. Each source has particular strengths and weaknesses.

- The National Household Survey by the National Institute on Drug Abuse (NIDA) collects self-reports of nonmedical drug use by persons age 12 and over. While the survey covers only those living in household units, it remains the primary source of drug abuse prevalence and trend data in the United States. Data concerning the Maryland portion of the 1990 National Household Survey sample are available.¹⁵ These local data are not representative of Maryland as a whole, however, but are representative of the Maryland portion of the Washington metropolitan area.
- Baltimore is one of 21 major metropolitan areas regularly reporting to the Drug Abuse Warning Network (DAWN), which collects information about drug-related hospital emergency visits and deaths reported by medical examiners. One episode is recorded each time a patient visits a DAWN emergency room and mentions drugs. Deaths are counted as the number of individuals whose cause of death was directly related to drug abuse as determined by a medical examiner. The DAWN system does not track emergency visits or deaths related to tobacco or to alcohol when not used in combination with other drugs.
- The 1992 Maryland Adolescent Drug Survey¹⁶ by the Maryland State Department of Education was designed to assess the use of tobacco, alcohol, and other drugs by Maryland public school students. The survey consisted of a self-administered questionnaire that was completed by students in grades 6, 8, 10, and 12 who were present in classes sampled on survey day.
- Data from substance abuse treatment facilities in Maryland are collected by the Substance Abuse Management Information System (SAMIS) of the Maryland Alcohol and Drug Abuse Administration. While only a fraction of those who could benefit from treatment

actually receive services from the substance abuse treatment system, the demographic characteristics and use patterns of those who do enter treatment provide insight into the nature of local substance abuse problems and those affected.

Summary statistics.

- On request, the Center for Substance Abuse Research (CESAR) of the University of Maryland sends weekly faxes summarizing research findings of local interest related to substance abuse. CESAR has also assembled a *Compendium of Drug Abuse Indicators*,¹⁵ which is updated periodically. The compendium summarizes data from the National Household Survey, DAWN, the Maryland Adolescent Drug Survey, SAMIS, and the criminal justice system. To be placed on CESAR's distribution list, physicians should call 301-403-8329.
- A chapter entitled "Nature and Extent of the Problem" is included annually in *Maryland's Drug and Alcohol Abuse Control Plan*,¹⁷ the development of which is coordinated by the Governor's Drug and Alcohol Abuse Commission. Copies of the plan can be ordered by calling 410-321-3521.
- *Straight Forward*, a newsletter published by the Med Chi Physician Rehabilitation Committee, regularly reports on local trends in substance abuse. The newsletter is sent quarterly to all Maryland physicians. Others interested in receiving the newsletter should call 800-992-7010 or 410-962-5580.

Substance abuse prevalence. The United States has witnessed a major drug abuse epidemic spanning the last three decades. NIDA estimates that less than 5% of the US population in the early 1960s had any experience with illicit drugs.¹⁸ By the time of the 1990 National Household Survey, however, an estimated 37% of Americans over the age of 12 had used illicit drugs at least once.^{19,20} Six percent of those surveyed were classified as current users, having used an illicit substance within the past month.²⁰ Of the substances included in the survey, alcohol was the most commonly used, with 73% annual and 59% current prevalence rates. Prevalence rates for marijuana were 10% annual and 5% current, and for cocaine, 3% annual and 1% current. Prevalence rates for the 1990 Maryland sample of the National Household Survey for annual and current use were similar to those for the national sample.

DAWN data show that drug-related emergency episodes in the Baltimore metropolitan area more than doubled from 1988 to 1991, totaling 11,000 in 1991. Of all the metropolitan areas DAWN surveyed, Baltimore had the largest increase in drug-related emergency episodes (74%)²¹ and in drug-related deaths (177%)²² from 1990 to 1991. The most frequently mentioned drug at emergency admission was cocaine (6,687 mentions), followed by heroin (3,892 mentions), alcohol-in-

combination with other drugs (3,115 mentions), and marijuana (355 mentions).²¹

The 1992 Maryland Adolescent Drug Survey¹⁶ indicated that alcohol was the most commonly used substance among school-age children, with lifetime, annual, and current prevalence of 34%, 23%, and 12%, respectively, in the 6th grade that increased steadily to 84%, 73%, and 53%, respectively, in the 12th grade. Of particular concern is the finding that many Maryland adolescents engaged in binge-drinking at least once in the year prior to the survey.

Cigarettes were the second most commonly used substance by Maryland adolescents, with 11% of 6th graders and 42% of 12th graders having used cigarettes in the year preceding the survey. Prevalence of use of drugs other than alcohol or tobacco in the preceding year increased from 9% in grade 6 to 34% in grade 12. The most commonly used illicit drugs were marijuana and inhalants.

Treatment issues. According to the Epidemiologic Catchment Area Study,²³ a national five-site survey that included Baltimore, the annual prevalence rate for any substance abuse disorder (excluding nicotine dependence) during the years 1980 to 1985 was 9.5%. Only 24% of persons identified as substance abusers received treatment services, however. Treatment was provided by mental health or addiction specialists for 11% of the substance abusers; a general medical practitioner for 10%; a human services professional for 4%; and by Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or friends and family for 8%.

Admissions to Maryland substance abuse treatment programs increased from approximately 40,000 in 1986 to 62,000 in 1992.²⁴ Approximately three-fourths of these admissions were first-time admissions. Less than 7% were referred to treatment by physicians or other health care providers working outside the alcohol and drug abuse treatment system.

Almost three-quarters of the patients were male, although the percentage of female patients has been increasing over time from 22% in 1990 to 27% in 1992. White patients comprised 56% and African-American patients 42% of those admitted. A time period of 5 to 10 or more years between first use of a substance and admission to treatment is common. Polydrug use is the norm, with more than half the patients at admission mentioning use of more than one substance. Of all patients admitted to Maryland treatment programs in 1992, three-quarters mentioned alcohol, 42% mentioned cocaine, 26% mentioned marijuana, and 22% mentioned heroin.

Ranking of the top four substances mentioned at treatment admission changes considerably when data for Baltimore patients are examined separately. In Baltimore treatment programs in 1992, cocaine was mentioned most frequently, followed closely by heroin and then alcohol, with marijuana mentioned approximately a third as often as the first three substances. From 1988 to 1992, the number of patients

mentioning alcohol or marijuana at treatment admission remained relatively stable or decreased slightly, while the growth in total treatment admissions over this period can be accounted for largely by the increasing number of new patients mentioning cocaine and heroin. These figures are consistent with the rise in cocaine- and heroin-related emergency episodes reported by DAWN. Injection drug use is of particular concern. Approximately two-thirds of Maryland's acquired immunodeficiency syndrome (AIDS) cases have come from Baltimore, where injection drug use is the leading risk factor for new AIDS cases.²⁵

There are over 300 certified substance abuse treatment sites in Maryland. Two-thirds of these sites receive state funding and are required to admit patients without regard to their ability to pay. Privately funded programs are often underused because of the small number of patients who can pay for services and the limited third-party reimbursement mechanisms. Recent reductions in state funding and the abolition of state-only Medicaid reimbursement has resulted in the closure of many publicly funded residential treatment programs and hospital-based detoxification units throughout the state. Even before the cutbacks, most publicly funded programs routinely operated very near to, or over, capacity. Baltimore has less than half the substance abuse treatment capacity needed to provide treatment on demand.

Lack of treatment facilities is particularly disturbing since research demonstrates the effectiveness of treatment.²⁶ Substance abuse treatment is not only effective in reducing alcohol and other drug abuse but also in improving psychological and social functioning, reducing rates of human immunodeficiency virus (HIV) seroconversion, increasing employment, and reducing criminal activity. And, although substance abuse is a chronic, relapsing disorder that typically requires multiple treatment episodes, evidence shows that public expenditures for substance abuse treatment are cost effective.

Physicians can make a difference

Considering the seriousness of the substance abuse problem in Maryland and the limited treatment options, physician involvement in the care of substance-abusing patients is critical. Several steps are recommended for physicians who are committed to improving their knowledge and skills regarding substance abuse:

- Continue to follow substance abuse trends and stay informed. Get on the distribution list for the CESAR reports and weekly faxes. Monitor Med Chi's quarterly newsletter, *Straight Forward*. Call for the latest copy of the governor's *Drug and Alcohol Abuse Control Plan*.
- Review the 1992 American Medical Association (AMA) *Guidelines for Adolescent Preventive Services*²⁷ and the 1979 *Guidelines for Physician Involvement in the*

Care of Substance-Abusing Patients.²⁸ Compare your own knowledge and skills to those required to be in compliance with these guidelines.

- Update your knowledge of substance abuse through local and national agencies. Read journals of the American Academy of Psychiatrists in Addictions, the Association for Medical Education and Research in Substance Abuse, and the American Society of Addiction Medicine. Attend the Med Chi Physician Rehabilitation Committee annual conference on substance abuse. (Med Chi also offers several continuing medical education (CME) programs on substance abuse that are available, free of charge, in either a presentation or self-study guide format.) Check the CME listings in the *Maryland Medical Journal* for other programs.
- Update your understanding of the substance abuse recovery process by attending one or more meetings of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), both of which have regular sessions that are open to the public. Ask a treatment program to allow you to attend an open group therapy meeting.
- Routinely screen all patients. While certain subpopulations have higher rates of substance abuse, no segment of society, age group, or geographic region is free from substance abuse problems. To increase the probability of early detection, use more than one diagnostic approach, including inductive reasoning, direct questioning, and diagnostic testing. Use one or more of the screening questionnaires developed to assist health care providers in diagnosing chemical dependence.
- Use your skills to motivate patients to accept treatment and begin the recovery process. Even limited interventions, such as brief warnings to reduce alcohol or drug intake, can be effective.
- Treat alcoholism and other drug dependence as primary chronic diseases where relapse is to be expected. Do not give up on patients with substance abuse problems any more than you would on patients with chronic diseases such as diabetes or hypertension. Treatment works.
- If you are unable or unwilling to treat patients' substance abuse problems, refer these patients to a certified treatment program.
- Familiarize yourself with substance abuse treatment programs that are accessible to patients in your community and get to know some of the treatment personnel. Contact the Maryland Alcohol and Drug Abuse Administration or your county or city health department for information on existing programs.
- If you are concerned about treatment reimbursement issues or the number or nature of substance abuse

treatment facilities in Maryland, write to your representatives in the state legislature.

The articles in this journal provide a good introduction to substance abuse issues for primary care physicians. The papers cover topics in screening, counseling, referral, and treatment, and supply references and resources for further learning. By working together with the substance abuse treatment community, well-informed and knowledgeable physicians can make a major contribution toward improving their patients' health and well-being and reducing levels of substance abuse in Maryland.

References

1. Baldwin WA, Rosenfeld BA, Breslow MJ, Buchman TG, Deutschman CS, Moore RD. Substance abuse-related admissions to adult intensive care. *Chest* 1993; 103:21-25.
2. Cleary PD, Miller M, Bush BT, Warburg MM, Delbanco TL, Aronson MD. Prevalence and recognition of alcohol abuse in a primary care population. *Am J Med* 1988; 85:466-71.
3. Magruder-Habib K, Durand AM, Frey KA. Alcohol abuse and alcoholism in primary health care settings. *J Fam Pract* 1991; 32:406-13.
4. Kamerow DB, Pincus HA, MacDonald DI. Alcohol abuse, other drug abuse, and mental disorders in medical practice. Prevalence, costs, recognition, and treatment. *JAMA* 1986; 255:2054-57.
5. Coulehan JL, Zettler-Segal M, Block M, McClelland M, Schulberg HC. Recognition of alcoholism and substance abuse in primary care patients. *Arch Intern Med* 1987; 147:349-52.
6. Friedman LS, Johnson B, Brett AS. Evaluation of substance-abusing adolescents by primary care physicians. *J Adolesc Health* 1990; 11:227-30.
7. Singer MI, Petchers MK, Anglin TM. Detection of adolescent substance abuse in a pediatric outpatient department: A double-blind study. *J Pediatr* 1987; 111:938-41.
8. Valente CM, Duszynski KR, Smoot RT, Ferentz KS, Levine DM, Troisi AJ. Physician estimates of substance abuse in Baltimore and Cumberland: 1991. *Md Med J* 1992; 41:973-78.
9. Physician Rehabilitation Committee. Med Chi presents substance abuse education program. *Straight Forward* 1992; 3(4).
10. Moore RD, Bone LR, Geller G, Mamon JA, Stokes EJ, Levine DM. Prevalence, detection, and treatment of alcoholism in hospitalized patients. *JAMA* 1989; 261:403-7.
11. Wallace P, Cutler S, Haines A. Randomized controlled trial of general practitioner intervention in patients with excessive alcohol consumption. *Brit Med J* 1988; 297:663-68.
12. Babor TF. Brief intervention strategies for harmful drinkers: New directions for medical education. *Can Med Assoc J* 1990; 143:1070-76.
13. Walsh DC, Hingson RW, Merrigan DM, et al. The impact of a physician's warning on recovery after alcoholism treatment. *JAMA* 1992; 267:663-67.
14. *Policy Report of the Physician Consortium on Substance Abuse Education 1991*. No. HRSA-P-DM-91-3, US Department of Health and Human Services.
15. Center for Substance Abuse Research. *Maryland Compendium of Drug Abuse Indicators*. University of Maryland. College Park, Maryland. May 1992.
16. *Maryland Adolescent Drug Survey 1992*. Maryland State Department of Education.
17. Governor's Drug and Alcohol Abuse Commission. *Maryland's Drug and Alcohol Abuse Control Plan 1992*.
18. National Institute on Drug Abuse. *Highlights from the National Survey on Drug Abuse: 1979*. DHHS Pub. No. (ADM)79-620. Washington, DC. 1979.
19. National Institute on Drug Abuse. *National Household Survey on Drug Abuse: Main Findings 1988*. Rockville: US Department of Health and Human Services. 1990.
20. National Institute on Drug Abuse. *National Household Survey on Drug Abuse: Main Findings 1990*. Rockville: US Department of Health and Human Services. 1992.
21. National Institute on Drug Abuse. *Annual Emergency Room Data 1991*. Series 1, Number 11-A. Rockville. 1992.
22. National Institute on Drug Abuse. *Annual Medical Examiner Data 1991*. Series 1, Number 11-13. Rockville. 1992.
23. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The *de facto* US mental and addictive disorders service system: epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry* 1993; 50:85-94.
24. Maryland Alcohol and Drug Abuse Administration. *Trends and Patterns in Alcohol and Drug Abuse in Maryland*. Fiscal Year 1992. Maryland Department of Health and Mental Hygiene. 1993.
25. Baltimore City Health Department. *Monthly AIDS Statistical Summary*. May 31, 1993.
26. *Treatment Works, The Tragic Cost of Undervaluing Treatment in the "Drug War," A Review of 15 Years of Research Findings on Alcohol and Other Drug Abuse Treatment Outcomes*. National Association of State Alcohol and Drug Abuse Directors. 1990.
27. American Medical Association. *Guidelines for Adolescent Preventive Services*. Department of Adolescent Health. ISBN No. 0-89970-530-8. 1992.
28. American Medical Association Council on Scientific Affairs. *AMA Guidelines for Physician Involvement in the Care of Substance-Abusing Patients*. Adopted October 8-9, 1979. ■

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Screening and assessment of alcohol and other drug abuse

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ABSTRACT: *Studies in medical, surgical, and gynecologic practices indicate that the prevalence of alcohol and other substance abuse among patients ranges from 20% to 50%. Although physicians are in a unique position to detect alcohol or drug abuse in their patients, they often fail to do so. Physicians are particularly unlikely to identify substance abuse in its earliest stages, and thus miss major opportunities for intervening. Several screening questionnaires for early detection of alcohol and other substance abuse have been developed. Alcohol abuse questionnaires have been the most extensively validated and have good sensitivity and specificity. Those developed for non-alcohol drug abuse are not well validated, but may be useful in clinical populations. Early biological laboratory markers of alcohol abuse are routinely available but are not as sensitive or specific as the screening questionnaires. Early biological markers of nonalcohol drug abuse are not yet well defined.*

A 51-year-old man presents to you because of episodic epigastric pain and diarrhea. He complains of increased stress at work and difficulty sleeping at night. He has had two minor traffic accidents in the past year. Physical examination reveals hypertension, but is otherwise normal. He says he smokes one to 1½ packs of cigarettes a day. When you ask him how much alcohol he uses, he tells you he only drinks socially. Laboratory results are remarkable only for a mean corpuscular volume (MCV) of 100 fL and a serum uric acid level of 482 µmol/L. Further evaluation reveals evidence of gastritis. You decide to treat him with antacids and a H₂ antagonist. You consider prescribing a short-acting benzodiazepine to help him sleep at night.

The patient described above is abusing alcohol. He has presented early enough in the course of his illness for a physician to identify his alcohol abuse

and to successfully intervene. Failure to diagnose alcohol abuse as his principal underlying problem could enable this patient to progress to more serious illness or to serious legal, occupational, or family problems. Use of a sedative in this patient could actually promote his continued alcohol abuse.

Studies in inpatient and ambulatory settings indicate that the prevalence of alcohol and other substance abuse among patients ranges from 20% to 50%.¹⁻⁶ Substance-abusing patients are common in internal medicine and family practices, as well as in surgical and gynecologic practices. Nevertheless, studies suggest that physicians, who are in a unique position to recognize these problems, often fail to identify alcohol or drug abuse.⁴

Physicians are particularly unlikely to identify substance abuse in its early stages and, indeed, report being ill-equipped to do so because of inadequate training, attitudinal barriers, and perceived lack of skill.⁷ Thus, many physicians miss major opportunities to intervene—the unintended consequences of which include increased morbidity and mortality due to substance abuse, and, for individual patients, problems in the economic, social, and legal realms.

Substance-abusing patients

Physicians can, however, learn to reliably identify substance abuse in their patients. To begin with, physicians should realize that any of their patients might be abusers of alcohol or other drugs. Research has shown that physicians are most likely to detect substance abuse in patients who best fit the current stereotype of a substance abuser: men, younger people, individuals of lower socioeconomic status, and people who have an antisocial personality.^{4,7} In fact, alcohol and other drug abuse can be present in anyone including women, older persons, and those who are wealthy or middle class. Awareness of this fact is the first step in identifying patients who are substance abusers.

Beyond this awareness, however, physicians must also have the skills necessary to detect alcohol or other drug abuse in their patients, particularly in the earlier stages when it may be less overt. Substance abusers with concomitant medical disease are more likely to be identified than substance abusers who do not yet manifest physical signs or symptoms.⁵

It is easier for physicians to diagnose substance abuse when patients present with late-stage physical damage such as liver disease and pancreatitis or when patients present with needle tracks on their arms and with endocarditis. At these stages, however, significant damage has already been done, and successful treatment is less likely.

Subtle symptoms and signs that can alert physicians to the possibility of substance abuse include insomnia; anxiety; depression; complaints of increased stress at work or increased family discord; minor accidents and trauma; requests for sedatives; minor gastrointestinal symptoms such as heartburn

or diarrhea; and hypertension. However, in some of these patients, these signs and symptoms may not be present, and the patients may still have an early substance abuse problem.

Screening questionnaires

Alcohol abuse. So how can busy physicians reliably identify patients who are abusing alcohol or other drugs? This question is easiest to answer for alcohol abuse since there are several screening questionnaires for early detection of alcohol abuse that have performed well in multiple studies of diverse patient populations. Ideally, a screening test should be both sensitive (to identify patients who have the disease) and specific (to avoid a false diagnosis of patients without the disease). A screening test should also be simple, inexpensive, and able to detect a problem for which there is a potentially successful treatment. The screening questionnaires described below meet these criteria.

Among the best of the questionnaires are the Michigan Alcoholism Screening Test (MAST) and the CAGE.^{8,9} The MAST is a 25-question instrument (**Table 1**). Although the MAST's questions can be included in an interview or in a written history that patients complete on their own, most physicians would find its length prohibitive for routine clinical use. A reading of its questions, however, can be instructive. The questions focus on the way alcohol use affects a person's life and not on how much the person drinks.

The CAGE, with only four questions, has been shown to have a utility similar to that of the longer MAST.¹⁰ CAGE* is an acronym for a key word in each of the questionnaire's four questions:

1. Have you ever felt you ought to **cut** down on your drinking?
2. Have people **annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**eyeopener**)?

A single affirmative response should raise a physician's level of concern. Two affirmative responses are considered a positive screen for alcohol abuse.

The CAGE is typically introduced to patients by asking if they have ever used alcohol. None of the CAGE questions ask patients how much they drink. There is no attempt to quantify the volume of liquor, beer, or wine, nor is there a question about beverage preferences.

Denial (to self and others) is common among substance-abusing persons. Questions about quantity or beverage preference, or questions that can be interpreted as accusatory in tone, are likely to promote denial in patients who abuse alcohol. Such questions generally provide physicians with

* Reprinted with permission from Ewing JA. Detecting alcoholism. The CAGE questionnaire. *JAMA* October 12, 1984; 252 (14): 1905-7.

Table 1. Michigan Alcoholism Screening Test*

1. Do you feel you are a normal drinker? (No = 2)
 2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening before? (Yes = 2)
 3. Does your spouse (or parents) ever worry or complain about your drinking? (Yes = 1)
 4. Can you stop drinking without a struggle after one or two drinks? (No = 2)
 5. Do you ever feel bad about your drinking? (Yes = 1)
 6. Do friends or relatives think you are a normal drinker? (No = 2)
 7. Do you ever try to limit your drinking to certain times of the day or to certain places? (No score)
 8. Are you always able to stop drinking when you want to? (No = 2)
 9. Have you ever attended a meeting of Alcoholics Anonymous (AA)? (Yes = 5)
 10. Have you gotten into fights when drinking? (Yes = 1)
 11. Has drinking ever created problems with you and your spouse (or parents)? (Yes = 2)
 12. Has your spouse (or other family member) ever gone to anyone for help about your drinking? (Yes = 2)
 13. Have you ever lost friends or girlfriends/boyfriends because of your drinking? (Yes = 2)
 14. Have you ever gotten into trouble at work because of your drinking? (Yes = 2)
 15. Have you ever lost a job because of your drinking? (Yes = 2)
 16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? (Yes = 2)
 17. Do you ever drink before noon? (Yes = 1)
 18. Have you ever been told you have liver trouble? Cirrhosis? (Yes = 2)
 19. Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that were not there after heavy drinking? (Yes = 2)
 20. Have you ever gone to anyone for help about your drinking? (Yes = 5)
 21. Have you ever been in a hospital because of your drinking? (Yes = 5)
 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem? (Yes = 2)
 23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or member of the clergy for help with an emotional problem in which drinking played a part? (Yes = 2)
 24. Have you ever been arrested, even for a few hours, because of drunk behavior? (Yes = 2)
 25. Have you ever been arrested for drunk driving or driving after drinking? (Yes = 2)
- ☐ 0-3 points = probably not alcoholic
 - ☐ 5 points = 80% diagnostic of alcoholism
 - ☐ 10 points or more = virtually 100% diagnostic of alcoholism

Total possible score = 53

(Most alcoholics score above 10 points)

*Reprinted with permission from Selzer ML. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *Am J Psychiatry* June 1971; 127(12): 89-94.

responses that underestimate the volume of use or with defensive responses such as, "I only drink socially," or "I only drink after work."

The quantity of alcohol consumed is probably less important than the effect of alcohol on a patient's life. Some persons may have two or three drinks a day without any adverse job, family, or health effects. A similar quantity in other persons may cause intellectual impairment, difficulty sleeping, tardiness for work,

or marital problems. Questions such as those on the CAGE or MAST were designed to determine if alcohol was disrupting a patient's life.

A positive response to any of the four CAGE questions provide an opportunity to ask more probing questions regarding a patient's use of alcohol. For example, if patients respond that they have tried to cut down, physicians could ask why the patients decided to cut down or if they were successful when they tried. If patients say that they were annoyed by criticism, physicians can ask what the patients thought caused the criticism or why they were bothered by it. Guilty feelings can be probed by asking patients if they ever regretted anything they said or did when drinking. And, patients who take a morning eyeopener can be asked whether they feel shaky in the morning and how drinking alcohol affects these shaky feelings.

Nonalcohol drug abuse. Unfortunately, there has been little research on screening questionnaires for nonalcohol drug abuse. One test, the Drug Abuse Screening Test (DAST), is a 28-item instrument that assesses abuse of illegal and prescribed drugs.^{11,12} The 30-item Drug and Alcohol Problem Quick Screen (DAP) has been developed¹³ for adolescent patients. As with the MAST, the questions on the DAST and DAP tend to be about the effects of

drug use on a patient's life, as opposed to quantifying frequency or volume of use.

A shorter "Use-Concern" questionnaire has been recommended for screening of either alcohol or nonalcohol drug abuse.* Its four questions are:

*This questionnaire was adapted from the work of Martin J. Valeske, M.D., of the George Washington University Medical Center. Dr. Valeske incorporated this questionnaire into the curriculum of the Blade Center for Clinical Practice and Research in Alcoholism at the Johns Hopkins Medical Institutions.

1. Do you **use** any mood-altering drugs?
2. Have you become **concerned** about your use of (the drug used)?
3. Has anyone else ever expressed their **concern** over your use of (the drug used)?
4. What is your definition of an addict?

Mood-altering drugs can refer to illicit drugs, such as cocaine, or to prescribed drugs, such as benzodiazepines. As with the CAGE, probing follow-up questions should be added to further explore any affirmative responses. It has been suggested that the CAGE can be adapted such that the four questions are asked in reference to nonalcohol drugs. Neither the Use-Concern nor the drug-use-adapted CAGE, however, has had sufficient scientific study to demonstrate their validity or generalizability with regard to identifying abuse of nonalcohol drugs.

Laboratory markers

Alcohol abuse. In addition to screening questionnaires, laboratory markers of alcohol and other substance abuse are useful in assisting physicians in identifying substance abuse. Again, most studies have been on alcohol abuse. The two biological markers that appear to be the earliest indicators of alcohol abuse are an elevated mean corpuscular volume (MCV) and an elevated serum gamma-glutamyl transpeptidase level (GGT).¹⁴⁻¹⁷ Neither is a very sensitive or specific marker of alcohol abuse, however.

Other laboratory markers such as an elevated serum aspartate-aminotransferase (AST) or an increased serum uric acid level, are even less sensitive markers that tend to occur at later disease stages. Newer laboratory markers, such as carbohydrate-deficient transferrin (CDT) or acetaldehyde-hemoglobin adducts,^{18,19} may be earlier and more sensitive markers of alcohol abuse, but these tests are not yet routinely available.

Nonalcohol drug abuse. Early biological markers of nonalcohol drug abuse are not as well defined. A urine toxicology screen may detect an illicit drug or its metabolites, but only reliably detects recent use. For example, opiates and their metabolites can be detected in urine for only 48 to 72 hours after use. Cocaine undergoes rapid cholinesterase metabolism and can be detected in urine for less than one week.²⁰

Toxicology screening may be useful when a patient presents at an emergency department with trauma.^{21,22} One recent study indicated that urine toxicology screening combined with a drug-use screening questionnaire increased the sensitivity of drug abuse detection in an obstetric population.²³ For routine ambulatory screening, however, a toxicology screen alone is likely to be relatively insensitive.

In summary, primary care physicians should be aware that alcohol and other substance abuse is a common problem among patients in clinical practices and that **any** patient may have a substance abuse problem. Relatively simple questions in-

corporated into the normal history taking followed, if necessary, by probing in a nonaccusatory, nonjudgmental manner, enables physicians to detect substance abuse in its early stages. Early identification of substance abuse is the first step in successful treatment.

References

1. Cleary PD, Miller M, Bush BT, Warburg MM, Delbanco TL, Aronson MD. Prevalence and recognition of alcohol abuse in a primary care population. *Am J Med* 1988; 85:466-71.
2. Bush B, Shaw S, Cleary P, Delbanco TL, Aronson MD. Screening for alcohol abuse using the CAGE questionnaire. *Am J Med* 1987; 82:231-35.
3. Ford DE, Kamerow DB. Screening for psychiatric and substance abuse disorders in clinical practice. *J Gen Intern Med* 1990; 5(suppl):S37-S41.
4. Moore RD, Bone LR, Geller G, Mamon JA, Stokes EJ, Levine DM. Prevalence, detection, and treatment of alcoholism in hospitalized patients. *JAMA* 1989; 261:403-7.
5. Moore RD, Malitz FE. Underdiagnosis of alcoholism by residents in an ambulatory medical practice. *J Med Educ* 1986; 61:46-52.
6. Buchsbaum DG, Buchanan RG, Centor RM, Schnoll SH, Lawton MJ. Screening for alcohol abuse using CAGE scores and likelihood ratios. *Ann Intern Med* 1991; 115:774-77.
7. Geller G, Levine DM, Mamon JA, Moore RD, Bone LR, Stokes EJ. Knowledge, attitudes and reported practices of medical students and house staff regarding the diagnosis and treatment of alcoholism. *JAMA* 1989; 261:3115-20.
8. Selzer ML. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *Am J Psychiatry* 1971; 127:1653-58.
9. Ewing JA. Detecting alcoholism: The CAGE questionnaire. *JAMA* 1984; 252:1905-7.
10. Mayfield D, McLeod G, Hall P. The CAGE questionnaire: Validation of a new alcoholism screening instrument. *Am J Psychiatry* 1974; 131:1121-23.
11. Skinner HA. The Drug Abuse Screening Test. *Addict Behav* 1982; 7:363-71.
12. Gavin DR, Ross HE, Skinner HA. Diagnostic validity of the drug abuse screening test in the assessment of DSM-III drug disorders. *Br J Addict* 1989; 84:301-7.
13. Schwartz RH, Wirtz PW. Potential substance abuse: Detection among adolescent patients. *Clin Pediatr* 1990; 29:38-43.
14. Ryback RS, Eckardt MJ, Felsher B, Rawlings RR. Biochemical and hematologic correlates of alcoholism and liver disease. *JAMA* 1982; 248:2261-65.
15. Whitfield JB, Allen JK, Adena M, Gallagher HG, Hensley WJ. A multivariate assessment of alcohol consumption. *Int J Epidemiol* 1981; 10:281-8.
16. Bernadt MW, Mumford J, Taylor C, Smith B, Murray RM. Comparison of questionnaire and laboratory tests in the detection of excessive drinking and alcoholism. *Lancet* 1982; 1:325-28.
17. Rossman AS. Utility and evaluation of biochemical markers of alcohol consumption. *J Subst Abuse Treat* 1992; 4:277-97.
18. Sillanaukee P, Seppa K, Koivula T, Israel Y, Niemela O. Acetaldehyde-modified hemoglobin as a marker of alcohol consumption: Comparison of two new methods. *J Lab Clin Med* 1992; 120:42-47.
19. Mihás AA, Tavassoli M. Laboratory markers of ethanol intake

and abuse: A critical appraisal. *Am J Med Sci* 1992; 303: 415-28.

20. Stewart DJ, Inaba T, Lucassen M, Kalow W. Cocaine metabolism: Cocaine and norcocaine hydrolysis by liver and serum esterases. *Clin Pharmacol Ther* 1979; 25:464-68.
21. Kirby JM, Maull KI, Fain W. Comparability of alcohol and drug use in injured drivers. *South Med J* 1992; 85:800-802.
22. Bailey DN. Drug use in patients admitted to a university trauma center: Results of limited (rather than comprehensive) toxicology screening. *J Anal Toxicol* 1990; 14:22-24.
23. Christmas JT, Knisely JS, Dawson KS, Dinsmoor MJ, Weber SE, Schnoll SH. Comparison of questionnaire screening and urine toxicology for detection of pregnancy complicated by substance abuse. *Obstet Gynecol* 1992; 80:750-54. ■

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Patients who use alcohol or other drugs: what to look for

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ABSTRACT: *Primary care physicians are often involved in the initial recognition of chemically dependent patients, even though physicians may ultimately refer such patients to specialists for treatment. To intervene effectively in the disease of chemical dependency, physicians need to know how to obtain and evaluate pertinent laboratory, physical, and historical information associated with drug and alcohol abuse.*

Chemical dependency, like other diseases, includes particular historical information, physical symptoms, and laboratory findings. Historical data, which are the most unique and specific, are, perhaps, the most important in diagnosing any illness. Specific physical findings may be caused by many diseases, while laboratory data are notoriously insensitive and nonspecific. To assist physicians in diagnosing chemical dependency, an overview of appropriate laboratory tests, suggestive physical findings, and pertinent information that can be obtained during history taking are provided below.

Laboratory findings

Laboratory parameters may be classified into toxicologic screening and other laboratory tests. Toxicologic screening procedures test for the presence of substances and their metabolites. Other laboratory findings are useful in diagnosing chemical dependency insofar as they reflect end-organ damage or abnormalities associated with illnesses secondary to substance abuse.

Toxicologic testing. Toxicologic testing can be performed on blood, breath, urine, or hair. Hair analysis is a fairly recent development in drug detection. While not providing information as to when a substance was used, hair analysis does yield information about substance usage over a fairly long period of time—that is, over the time that the hair has grown. Ingested substances are incorporated into the hair as it is formed, so that a positive test result could reflect substance use within a period as long as a month or more, depending on the length of hair. Hair analysis can establish, for example, whether a patient with recurrent arrhythmias but who denies using cocaine,

is being truthful. Not all laboratories analyze hair, and physicians should check to see if hair analysis is available.

The two principal testing methods for alcohol consumption are blood and breath tests. While blood tests are useful in an emergency setting, they are often impractical for use by a physician in a primary care practice. Breath-testing devices, however, are easily obtained and employed in the primary care office. Since the proportion of alcohol in exhaled air is directly related to the proportion of alcohol in the blood stream,¹ physicians should administer the test when alcohol is noticed on a patient's breath.

Test results for alcohol will usually revert to zero less than 12 hours after a person has stopped drinking. Alcohol is metabolized in a linear fashion according to zero-order kinetics. The ability to metabolize alcohol is proportional to the size of the individual and is approximately 120 mg/kg/hr. This is equivalent to about one ounce of 100% ethanol in three hours, resulting in a decline rate of blood alcohol levels of about 35 mg/dL per hour. This makes forensic determination of alcohol levels fairly straight forward.

If, for example, a 160-pound individual consumes three 12-ounce beers, the maximal blood alcohol level will be approximately 70 mg/dL, which will decline to zero in two to four hours. Based on my experience as an addictions specialist, the following blood alcohol levels can be considered highly indicative of alcoholism: a blood alcohol level of 100 mg/dL during a routine office visit; a level of 200 mg/dL without indication of impairment; or a level of 300 mg/dL at any time.

Testing for other drugs is usually done by urinalysis. Most current drugs of abuse—marijuana, cocaine, amphetamines, and the opiates—produce a positive urinalysis result for approximately 72 hours after use. Toxicologic urinalyses use screening tests with high sensitivity and low specificity, followed by confirmatory tests of high sensitivity and high specificity. Methodologies including thin layer chromatography, enzyme-multiplied immunoassay tests (EMITs), and radioimmunoassay tests are used.

Each toxicologic urinalysis method has its uses and limitations. In screening for benzodiazepines with thin layer chromatography, for example, each individual substance must have a reference standard, and EMITs can only test one substance at a time. A sufficient quantity of urine must be obtained. Typically, 60 ml of urine is sent to the laboratory. While 30 ml is sufficient for testing purposes, 30 ml is retained in case confirmation is needed.

Patients who deny using a substance in spite of a positive toxicology result may have used a confounding substance. Over-the-counter cold remedies that contain ephedrine or pseudoephedrine, for example, can produce a positive result for amphetamines, and poppy seeds can render positive results for opiates. Contrary to some rumors, there is no evidence, that melanin causes a positive result for marijuana in African-

American patients. And, within the scope of office practice, it is safe to say that a positive result for marijuana is not related to passive inhalation.² At the 20 ng/ml cutoff level on the EMIT for marijuana, only spending prolonged periods of time in a small enclosed space with multiple marijuana smokers would render a positive result.

In a clinical sense, the presence of even minute quantities of a drug or drug metabolite indicates that the substance has been ingested. For work- and legal-related issues, however, the National Institute on Drug Abuse (NIDA) cutoff levels are used to determine whether a result is positive. Physicians who wish to learn more about specific cutoff levels and durations of positive tests should consult toxicologic references³⁻⁵ or a medical review officer (MRO).

Other laboratory tests. Some hematologic markers suggest alcoholism. Without exception, however, they are of low sensitivity. Malnutrition secondary to alcoholism may result in hypomagnesemia, hypophosphatemia, and B-vitamin deficiencies. White blood cells may be multinucleated as a result of vitamin B₁₂ deficiency. Erythrocytes may be enlarged due, in part, to a nutritional deficiency. There is some evidence, however, that alcohol is toxic to red blood cell membranes and that this toxicity leads to macrocytosis.⁶ Anemia may also be present. Since nutritional anemia, including iron deficiency, sometimes has elements of microcytosis, a Coulter counter or averaging device may reveal a normocytic normochromic anemia even though alcoholism is present. A smear will reveal these abnormalities more specifically. It is also possible to observe erythrocyte macrocytosis without anemia and to observe a nutritionally induced anemia without macrocytosis.

Serum transaminases may be elevated, particularly gamma-glutamyl transpeptidase (GGT), which is the most sensitive indicator of toxic hepatic damage.⁷ When glutamic-oxaloacetic transaminase (SGOT) and glutamate pyruvate transaminase (SGPT) are elevated by alcoholic liver damage, SGOT tends to be more elevated than SGPT. Elevations of amylase may indicate alcoholic pancreatitis.

Leukocytosis, related to secondary infection, may be present. Alcohol- and drug-dependent individuals are prone to secondary infectious illnesses, often as a result of the route of administration, with intravenous drug abuse the most likely to produce infection. Intravenous drug users should be encouraged to submit to screening for HIV (human immunodeficiency virus) antibodies. An absolute neutropenia of less than 2,000 cells/m³ should prompt physicians to look for further specific white cell abnormalities.⁸ The principal indicator of HIV infection, which also carries clinical significance, will be a low absolute or relative count of CD4+ T cells.

Urinalysis may reveal proteinuria related to heroin-induced nephropathy. Smoking crack cocaine or marijuana often impairs pulmonary defenses and predisposes individuals to secondary pulmonary infections. Of particular

interest is the increased incidence of aspergillosis in patients who smoke marijuana.

Physical findings

Since every organ system may bear stigmata of drug- or alcohol-induced illness, a comprehensive physical examination is of great value in screening for addictive disorders.

Eyes and nose. Erythematous mucosa of the nasal passages, with or without erosions, may indicate cocaine use. Conjunctival injection (redness of the eyes), though nonspecific, is often found in connection with recent drug or alcohol use. Nystagmus has a stronger correlation and vertical-nystagmus may be related to either marijuana or phencyclidine (PCP) use.⁹ Dilation of the pupils may indicate hallucinogen or stimulant abuse, while constriction may indicate opiate use.

Skin. The skin is often the marker for a number of drug- and alcohol-related conditions. Some stimulant abusers, after long periods of use, believe that there are bugs crawling under their skin. Efforts to rid themselves of these "bugs" result in excoriations and scabbed sores.

The skin should also be examined for needle marks, which typically present as punctate scabbed lesions. "Tracks" refer to sclerosis of veins that have been injected repeatedly. These are commonly found in the dorsum of the hand or the antecubital fossa, but may also be found in more obscure sites, such as between the toes or on the genitals. People who have injected drugs for many years may no longer have access to more peripheral veins, so that injection marks may be found in the neck and femoral veins. The skin may also exhibit the general icterus of a patient with alcoholic liver disease or the sallow complexion of a patient who is chronically malnourished. These latter findings are not as specific for injected drug or alcohol use.

Circulatory system. Systolic hypertension or hypertension that is refractory to treatment may be secondary to alcoholism or stimulant abuse. Rapid pulse rates may be associated with volume depletion or stimulant use, while heart murmurs can indicate valvular infections secondary to intravenous injection of contaminated substances.

Respiratory system. Dry inspiratory crackles created when fibrotic alveoli are expanded during inhalation may be observed in patients who smoke substances such as cocaine, marijuana, or PCP. Edema related to pulmonary hypertension and congestive heart failure may also be evident after years of deposition of intravenous drug contaminants in the pulmonary capillary bed.

Digestive system. Alcoholic liver damage may occur in two situations. Initially, with fatty infiltration or alcoholic hepatitis, the liver is tender and enlarged. In late-stage alcoholism, the liver may be shrunken, hard, nodular, and sclerosed, indicative of cirrhotic changes. Alcohol-induced pancreatitis

may present with back pain and diffuse abdominal pain in severe cases.

Genitourinary system. Sexually transmitted diseases (STDs) should trigger a closer evaluation for drug- or alcohol-related problems, since the incidence of these diseases increases in chemically dependent populations. It is not yet clear whether the relative immunosuppression induced by chronic drug and alcohol use predisposes individuals to infection by STDs.

Nervous system. Injection of synthetic opiates can produce a Parkinson-like syndrome that develops acutely and is typically irreversible.¹⁰ Patients who present with diffuse rigidity and a history of intravenous drug abuse should be referred for neurologic evaluation.

Peripheral neuropathy is common in alcoholic patients and may present as foot drop or painful mononeuritis in peripheral distributions. Abnormal deep tendon reflexes, including hyperactive patellar reflexes and tremulousness of the extended upper extremities, may also be noted in the alcoholic patient. In the intravenous drug user, there may be a focal neurologic deficit related to embolization or abscess formation in the central nervous system.

Lymphatic system. Diffuse generalized lymphadenopathy may be an early indication of HIV infection, while specific areas of adenopathy may be related to the draining of areas inflamed or infected during intravenous drug use.

Historical data

Historical screening for drug- and alcohol-related information is appropriate in evaluating **all** patients, since no particular patient or type of patient is immune to developing a drug or alcohol dependency. Screening questionnaires such as the CAGE, MAST, and DAST are extremely useful during history taking.^{11,12}

Good history taking requires physicians to gain patient trust. Physicians should question patients in an objective, nonjudgmental, and supportive tone. Patients who seem offended by inquiries into their drug and alcohol use can be reminded that physicians' primary interest is in patient health and told that such inquiries are a part of responsible screening. Most patients readily accept this and appreciate the interest.

Angry or emotional responses to questions about alcohol or drug consumption, however, suggest a dependency problem. Indeed, because of the central role that drugs or alcohol play in some peoples' lives, strong emotional reactions regarding their substance of choice are typical of alcoholic individuals and those addicted to drugs. The question, "What is it you enjoy most about drinking/taking drugs?" often elicits evidence of substance abuse. While most social drinkers and casual drug users will find this question difficult to answer, alcoholic or drug-addicted patients will discuss their substance of choice in terms usually reserved for a best friend or lover.

As physicians develop longstanding relationships with patients, they will begin to recognize behavior patterns. No single incident, such as an alcohol-related traffic arrest, is diagnostic of alcoholism or addiction. Patterns of behavior, however, such as increasing problems in the home coupled with a series of minor accidents, should alert physicians to the possibility of an underlying chemical dependency disorder.

It is while taking a history that physicians are most likely to discover the psychological disorders that are so prominent in drug- or alcohol-dependent patients. These disorders can occur as a consequence of chronic substance abuse, as a result of the adverse life occurrences associated with an addictive illness, or as a primary endogenous illness coincident with addiction. Sleep-related complaints, fatigue, and personality and mood disorders are commonly encountered.

Personality disorders are more prevalent during active use and addiction and in early recovery.¹³ Anxiety and depression occur with increased incidence in addicted and alcoholic patients and may be either primary or secondary illnesses.¹⁴ Anxiety and depression may result from stimulant use, and anxiety may also occur during withdrawal from alcohol or from sedatives or hypnotic drugs. Chronic fatigue may be related to malnutrition or, more usually, to sleep deprivation, since essentially all substances of abuse can disturb normal sleep architecture. Indeed, a proper sleep evaluation requires abstinence from alcohol and other drugs.

Sensitivity to, and appropriate management of, the psychological complaints associated with substance abuse facilitate acceptance of the chemical dependency diagnosis. Acceptance of the diagnosis leads to an acceptance of appropriate treatment. While some physicians may not want to render definitive treatment, chemically dependent patients can be referred to licensed treatment centers. Given the potentially lethal nature of chemical dependency disorders, early detection and referral of patients with these disorders is crucial.

References

1. Goodman AG, Gilman LS, Rall TW, Murad F. *The Pharmacological Basis of Therapeutics* (7th ed). New York: Macmillan Publishing Company. 1985: 380.
2. Morland J, Bugge A, Skuterud B, Steen A, Wethe GH, Kjeldsen T. Cannabinoids in blood and urine after passive inhalation of cannabis smoke. *J Forensic Sci* 1985; 30:997-1002.
3. Council on Scientific Affairs. Scientific issues in drug testing. *JAMA* 1987; 257(22):3110-14.
4. Hawks RL, Chiang CN (eds). *Urine Testing for Drugs of Abuse*. US Department of Health and Human Services. Publication ADM 87-1481. Rockville, Maryland: National Institute on Drug Abuse. 1986.
5. Schwartz RH. Urine testing in the detection of drugs of abuse. *Arch Intern Med* 1988; 148:2407-12.
6. Ryback RS, Eckardt MJ, Paulter CP. Biochemical and hematological correlates of alcoholism. *Res Commun Chem Pathol Pharmacol* 1980; 27:533-50.

7. Milhorn HT Jr. The diagnosis of alcoholism. *Am Fam Physician*. 1988; 37(6):175-83.
8. Blatt SP, Lucey CR, Butzin CA, Hendrix CW, Lucey DR. Total lymphocyte count as a predictor of absolute CD4+ count and CD4+ percentage in HIV-infected persons. *JAMA* 1993; 269: 622-26.
9. Wilford BB (ed). *Syllabus for the Review Course in Addiction Medicine*. Washington, DC: American Society of Addiction Medicine. 1990; 106.
10. Ling W, Wesson DR. Drugs of abuse—opiates. *West J Med* 1990; 152:565-72.
11. Ewing JA. Detecting alcoholism: The CAGE questionnaire. *JAMA* 1984; 252:1905-7.
12. Selzer ML. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *Am J Psychiatry* 1971; 127(12):89-94.
13. Blume SB. Dual diagnosis: psychoactive substance dependence and the personality disorders. *J Psychoactive Drugs* 1989; 21(2):139-44.
14. Mirin SM, Weiss RD. Affective illness in substance abusers. *Psychiatr Clin North Am* 1986; 9(3):503-14.

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Helping patients stop smoking

Kevin Scott Ferentz, M.D., and Carmine M. Valente, Ph.D.

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ABSTRACT: *As more patients seek treatment for nicotine addiction, physicians must become adept at counseling patients on how to quit. Several simple behavioral modification techniques are available to help patients stop smoking, and these techniques can be incorporated into any busy practice. Any patient encounter can be used to inform patients of the dangers of smoking and to tell them to quit. Patients can be offered nicotine replacement therapy, although the long-term benefit is still unknown. Helping patients to quit is a rewarding process.*

Since the US surgeon general's first report on cigarette smoking in 1964, smokers have been under increasing pressure to quit. Thirty years after that report, however, cigarette smoking remains the number one cause of disease, disability, and premature death in this country¹; one in five deaths can be attributed to cigarette smoking.² In 1989, Maryland spent over a billion dollars on smoking-related illness, disability, and health care.³ Today, because so many smokers remain addicted to nicotine, an unprecedented amount of pressure is being placed on them to quit. This pressure, both subtle and overt, is coming from a number of sources, including

- local, state, and federal legislatures, which continue to pass laws making it more difficult and expensive for smokers to continue smoking;
- state and local public health initiatives that inform citizens of the mounting evidence against smoking and secondhand smoke;
- nonsmokers who refuse to expose themselves to cigarette smoke.

Given the efforts of these groups, physicians may encounter growing numbers of patients interested in stopping smoking. Since even brief interventions by physicians have been shown to be effective in helping patients quit,⁴ physicians should become adept at counseling patients who smoke and, in effect, become experts in smoking cessation.

Demographics

Over 46 million Americans smoke cigarettes, and almost as many women smoke as men.⁵ While 1.3 million smokers quit each year, a large number of teenagers begin smoking.⁶ Cigarette smoking prevalence decreases with increasing education and is highest among those who live below the poverty level.⁵ While smoking has declined steadily since 1974, projected prevalence for the year 2000 is 30% of those with 12 or fewer years of education; 10% of college graduates; 20% of men; 23% of women; 25% of African-Americans; and 21% of whites.⁶

Health effects

Physicians are seen by patients as the most credible source of health information. As such, they are in a powerful position to influence behavior and should use that influence in a positive way. New information is regularly reported concerning the health effects of smoking. It is incumbent upon physicians to inform patients who are not yet ready to quit about these health effects. The point is not to frighten patients but to help them make the best decisions regarding their health. The following information should be shared.

Cancer. Cigarette smoking is responsible for 30% of all cancers in America.⁷ Lung cancer has exceeded breast cancer as the number one cause of cancer death in women.⁸ There are increased risks of cancer in all organs that come in contact with cigarette smoke or its by-products; these organs include the mouth, tongue, pharynx, larynx, esophagus, stomach, kidney, and bladder.^{8,9}

Heart disease. Coronary heart disease is the number one killer in the United States, and smoking is a major risk factor in its development. Male smokers ages 45 to 64 are significantly more likely to die of a heart attack than their nonsmoking counterparts.¹⁰ Smokers concerned about their cholesterol levels should be told of the even greater risk associated with cigarette use.

Lung disease. Smokers are overwhelmingly more likely to develop chronic lung disease than are nonsmokers.¹⁰ Lung disease is a major cause of reduced quality of life in older patients. Patients who counter physicians' smoking cessation efforts with statements such as, "So if I get cancer, I'll die. Everyone has to die of something," can be told, "That's true, but you may get emphysema and live miserably."

Women's health. Women who smoke have an increased risk of cervical cancer¹¹ and can experience impaired fertility due to nicotine's effect on ovulation.¹² Compared with pregnant nonsmokers, pregnant smokers are at greatly increased risk of delivering prematurely and tend to have smaller babies.¹³ Women smokers also go through menopause earlier than nonsmoking women.¹⁴ They, therefore, tend to have lower estrogen levels and increased osteoporosis.

Children's issues. Infants born to women who smoke during pregnancy are more than twice as likely to have sudden infant death syndrome (SIDS) and are more likely to be hospitalized during the first year of life for respiratory illness.^{15,16} These children also have an increased incidence of long-term cognitive and behavioral abnormalities,¹⁷ as well as otitis media.¹⁸

Other health concerns. Smoking is the primary cause of house fires leading to fatalities¹⁹ and a major cause of dental problems, including gingival recession and periodontal bone loss.^{20,21} Smoking also causes increased skin wrinkling.²²

Secondhand smoke. There is mounting evidence that secondhand smoke (passive smoking) is a major hazard. Secondhand smoke clearly increases the risk of cardiovascular and lung diseases for those living with spouses who smoke in the home.²³ A report sponsored by the Environmental Protection Agency (EPA) concluded that passive smoking annually kills 53,000 nonsmokers and is a major cause of indoor air pollution. This and other reports add momentum to the notion that more smoke-free environments must be created.²⁴

What motivates a smoker to stop?

Smokers go through four distinct phases on the way to quitting: precontemplation, contemplation, preparation, and action.²⁵ Each phase involves increasing levels of motivation. Physicians can assess motivational levels by asking smokers if they have considered quitting and whether they would be willing to try to stop smoking within the next month. Advice to patients should be tailored to the motivational level.

1. **Precontemplation phase.** (Patient has no intention of changing behavior within the next six months.) Establish a noncoercive relationship. Be caring and understanding but concerned. Help the patient move to the next level in a nonjudgmental way.
2. **Contemplation phase.** (The patient is seriously thinking of changing behavior.) Encourage the patient by expressing confidence in his or her ability to stop.
3. **Preparation phase** (The patient is planning to take action within the next month.) Teach the behavioral modification skills necessary to make cessation likely.
4. **Action phase** (This phase lasts from day one through the first six months of cessation.) Help to prevent relapse with follow-up visits.

Patients need to hear a firm, unambivalent anti-smoking message from their physician. Simply stating, "As your physician, I am telling you to quit smoking," can have a profound impact.

Behavior modification

Behavior modification techniques can be taught in a short period of time to smokers who want to quit. Such techniques

give patients the skills necessary to combat the psychological and behavioral aspects of nicotine addiction. Patients who want to quit should be given an appointment specifically to learn behavior modification techniques and learn how the techniques fit into a total smoking cessation program.

At the first visit, patients should be given a two- to three-week period in which to prepare for quitting. This gives them time to complete the steps preparatory to stopping. However, the steps can be completed in less than a week for patients who wish to stop sooner. Steps in the smoking cessation program, as well as their rationale, follow.

Step 1. List reasons for quitting. Have patients spend a day thinking about their reasons for wanting to quit. Examples are to stay healthy, to save money, or to enhance self-esteem. Have patients list their own reasons on an index card and encourage them to carry the card with them at all times, especially after quitting.

Rationale. When patients stop smoking, they continue to crave nicotine. These cravings last three to five minutes whether or not patients smoke a cigarette. Reminding themselves of their reasons for quitting by reading their index card helps patients get through their cravings.

Step 2. Identify triggers. Have patients keep a diary of their smoking habits for four days. For each cigarette smoked, patients should write down where the cigarette was smoked, at what time, in whose company, what it felt like, and the reason for smoking it. After four days, patients should review the diary and identify what situations, emotions, locations, or times they associate with smoking. They should then divide a piece of paper in half and list on the left side what triggers them to smoke.

Rationale. All smokers associate certain situations with smoking. Some common smoking triggers include driving, talking on the telephone, drinking coffee or alcohol, and being in stressful situations. Smokers need to identify their own triggers in order to plan how they will deal with each one after they have quit.

Step 3. Identify coping mechanisms. Have patients identify a coping mechanism for each of their triggers and write it on the right side of the paper opposite the appropriate trigger. The mechanism can be behavioral (such as doing something active) or cognitive (such as thinking of the rewards of stopping smoking). Patient education pamphlets describing such coping mechanisms are available from the National Cancer Institute (1-800-4-CANCER).

Rationale. Patients should know in advance what they will do in response to trigger situations. They should pay particular attention to developing effective coping mechanisms for those triggers that they have had the greatest problems dealing with in the past.

Step 4. Change brands. Have patients buy only one pack of cigarettes at a time (no cartons) and switch brands each time they buy a pack.

Rationale. Smokers are generally loyal to a particular brand. Having them switch often causes an aversion effect. Smokers used to a high tar and nicotine cigarette, for example, will get less pleasure from a low tar and nicotine brand, while patients used to low tar and nicotine brands can actually become ill from smoking a high tar and nicotine cigarette. These aversion effects help patients look forward to quit day.

Step 5. Set up a reward system. Have patients reward themselves for each day they succeed in not smoking. Daily rewards, such as being allowed to skip a household chore, give patients a tangible incentive for not smoking. After a week of not smoking, patients might reward themselves with dinner at a favorite restaurant. At their one-month anniversary, they might plan a weekend trip. At their one-year anniversary, patients should be encouraged to give themselves a big reward, such as a new car or stereo system.

Rationale. All individuals are more likely to complete a difficult task if they know they will be rewarded at the end.

Step 6. Inform everyone. Have patients tell everyone they know that they are going to quit smoking.

Rationale. Help and support are essential, especially during the first few weeks of quitting. Other people (even smokers) are generally supportive of smokers who are trying to quit.

Step 7. Set a quit day. Have patients plan a specific quit date before the end of their first quit-smoking visit with you.

Rationale. Setting a specific date constitutes a commitment.

Step 8. Make a return appointment. Have patients make an appointment to see you two to four weeks after their quit date.

Rationale. Setting a follow-up appointment emphasizes your concern about patients' cessation efforts. Since relapse is common, smoking should be treated as a chronic problem, and patients with chronic problems should be seen on a regular basis. Patients who do not return for the

follow-up visit should be contacted and asked about their progress. Another appointment should be set for those who have relapsed so that you can reiterate your concern about smoking.

Nicotine replacement therapy

The idea behind nicotine replacement therapy is simple: patients addicted to nicotine receive the substance, either through a patch or gum, for a limited time so that they can work separately on the behavioral aspects of quitting. Symptoms associated with nicotine withdrawal and cigarette cravings are delayed and diminished. However, without counseling, which addresses the psychosocial aspects of cigarette smoking, nicotine replacement therapy works no better than a placebo.²⁶ Several options for nicotine replacement are available.

Nicotine gum. Nicorette gum has been on the market for more than 10 years. Quit rates for the gum are similar to those for nicotine patches.²⁷ Chewing the gum properly, however, is a problem for some people. Patients should chew the gum until they feel a tingling sensation, indicating the release of nicotine, and then stop chewing. The gum should then be placed between their cheek and gum—so-called “parking.” When the tingle disappears, patients should begin chewing again. One piece of gum should last 30 minutes. Most patients do not chew enough pieces of gum; a general guideline is that smokers should chew the number of pieces of gum equivalent to at least half the number of cigarettes they were accustomed to smoking.

Nicotine patches. More than one billion dollars worth of nicotine patches were sold in their first year on the market.²⁶ In later years, however, the number sold dropped precipitously with the realization that patients must still be motivated to quit and must be counseled regarding the behavioral aspects of smoking. Although nicotine patches are well tolerated, relapse rates are high.²⁶ There have been no studies comparing the effectiveness of the four different patches on the market. There are also no data to support choosing a product that tapers the nicotine (e.g., Nicoderm, Habitrol, and Nicotrol) versus one that does not (e.g., Prostep).

There is no simple way to determine which patients should be offered nicotine replacement therapy. The Fagerstrom tolerance test, which classifies patients as to “low” or “high” nicotine dependence, can be used to categorize patients.²⁸ Theoretically, patients with high dependence should benefit more from nicotine replacement therapy. Practically speaking, patients who believe they will benefit from nicotine replacement should probably be offered that option. All patients, however, must still receive counseling. Patients should understand that it is strong motivation, not nicotine replacement, that will make them successful.

Relapse prevention

Nearly 70% of smokers will relapse within the first year that they stop smoking.²⁹ The majority relapse within the first week.³⁰ Those who relapse early are usually responding to cravings and withdrawal symptoms, while late relapse is often a response to crisis, depression, or being in the presence of many smokers. Several techniques can be used to prevent relapse.

- *Refinement of coping skills.* Encourage patients to continue to identify smoking triggers and decide on which coping skills to use when such situations arise.
- *Positive self-talks in response to slips.* Smoking a single cigarette has been found to be the most reliable indicator of eventual relapse,³⁰ and many patients do occasionally smoke a cigarette after initially quitting. Do not make patients feel guilty about these slips. Encourage patients to use the slips as learning experiences. Help them determine what the particular trigger was, and then help them decide what they will do to counter the trigger in the future.
- *Continued commitment.* As with any addiction, smokers should be taught to fight the addiction one day at a time.
- *Ongoing praise and encouragement by physicians.* After friends and family have forgotten that a patient smoked and after the novelty has worn off for the patient, physicians are in a perfect position to provide ongoing booster doses of support. Each time you see former smokers, remind them of the pride they should have in their accomplishment. This reinforces patients' resolve and helps keep them away from cigarettes.

References

1. Centers for Disease Control. *Reducing the Health Consequences of Smoking: 25 Years of Progress—A Report of the Surgeon General, 1989.* DHHS Publication No. (CDC)89-8411. Rockville, Maryland: US Department of Health and Human Services. 1989.
2. Centers for Disease Control. Cigarette smoking. Attributable mortality and years of potential life lost—United States, 1990. *MMWR Morb Mortal Wkly Rep* 1993; 42:645-49.
3. Maryland Department of Health and Mental Hygiene. *The Costs of Cigarette Smoking.* Baltimore, Maryland: Local and Family Health Administration. 1991.
4. Russell MAH, Wilson C, Taylor C, Baker CD. Effect of general practitioner's advice against smoking. *BMJ* 1979; 2:231-35.
5. Centers for Disease Control. Cigarette smoking among adults—United States, 1991. *JAMA* 1993; 269:1931.
6. Pierce JP, Fiore MC, Novotny TE, Hatzianandreu EJ, Davis RM. Trends in cigarette smoking in the United States. Projections to the year 2000. *JAMA* 1989; 261:61-65.
7. Newcomb PA, Carbone PP. The health consequences of smoking: Cancer. *Med Clin North Am* 1992; 76:305-31.

8. Cresanta JL. Epidemiology of cancer in the United States. *Prim Care* 1992; 19:419-41.
9. Carbone D. Smoking and cancer. *Am J Med* 1992; 93(1A):13S-17S.
10. Sherman CB. Health effects of cigarette smoking. *Clin Chest Med* 1991; 12:643-58.
11. Slattery ML, Robinson LM, Schuman KL, et al. Cigarette smoking and exposure to passive smoke are risk factors for cervical cancer. *JAMA* 1989; 261:1593-98.
12. Harrison KL, Breen TM, Hennessey JF. The effect of patient smoking habits on the outcome of IVF and GIFT treatment. *Aust N Z J Obstet Gynaecol* 1990; 30:340-42.
13. Centers for Disease Control. Effects of maternal cigarette smoking on birth weight and preterm birth—Ohio, 1989. *MMWR Morbid Mortal Wkly Rep* 1990; 39:662-65.
14. Midgette AS, Baron JA. Cigarette smoking and the risk of natural menopause. *Epidemiology* 1990; 1:474-80.
15. Schoendorf KC, Kiely JL. Relationship of sudden infant death syndrome to maternal smoking during and after pregnancy. *Pediatrics* 1992; 90:905-8.
16. Harlap S, Davies AM. Infant admission to hospital and maternal smoking. *Lancet* 1974; 1:529-32.
17. Weitman M, Gortmaker S, Sobol A. Maternal smoking and behavior problems of children. *Pediatrics* 1992; 90:342-49.
18. Kraemer MJ, Richard MA, Weiss NS, et al. Risk factors for persistent middle-ear effusions. *JAMA* 1983; 249:1022-25.
19. Runyan CW, Bangdiwala SI, Linzer MA, Sacks JJ, Butts J. Risk factors for fatal residential fires. *N Engl J Med* 1992; 327:859-63.
20. Fenstad AM. Smoking and periodontal disease. *Northwest Dentistry* 1991; 70:27.
21. Christen AG. The impact of tobacco use and cessation on oral and dental diseases and conditions. *Am J Med* 1992; 93(1A):25S-31S.
22. Kadunce DP, Burr R, Gress R, Kanner R, Lyon JL, Zone JJ. Cigarette smoking: risk factor for premature facial wrinkling. *Ann Intern Med* 1991; 114:840-44.
23. Shaham J, Ribak J, Green M. The consequences of passive smoking: an overview. *Public Health Rev* 1992-1993; 20:15-28.
24. Lesmes GR, Donofrio KH. Passive smoking: the medical and economic issues. *Am J Med* 1992; 93:38S-42S.
25. Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. *J Consult Clin Psychol* 1983; 51:390-95.
26. Fiore MC, Jorenby DE, Baker TB, Kenford SL. Tobacco dependence and the nicotine patch. *JAMA* 1992; 268:2687-94.
27. Gora ML. Nicotine transdermal systems. *Ann Pharmacother* 1993; 27:742-50.
28. Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom test of nicotine dependence: A revision of the Fagerstrom tolerance questionnaire. *Br J Addict* 1991; 86:1119-27.
29. Shiffman S, Read L, Maltese J, Rapkin D, Jarvik ME. Preventing relapse in ex-smokers: A self-management approach. In: Marlatt, GA, Gordon JR (eds). *Relapse Prevention*. New York: The Guilford Press. 1985. pp. 472-520.
30. Garvey AJ, Bliss RE, Hitchcock JL, Heinhold JW, Rosner B. Predictors of smoking relapse among self-quitters: a report from the Normative Aging Study. *Addict Behav* 1992; 17:367-77. ■



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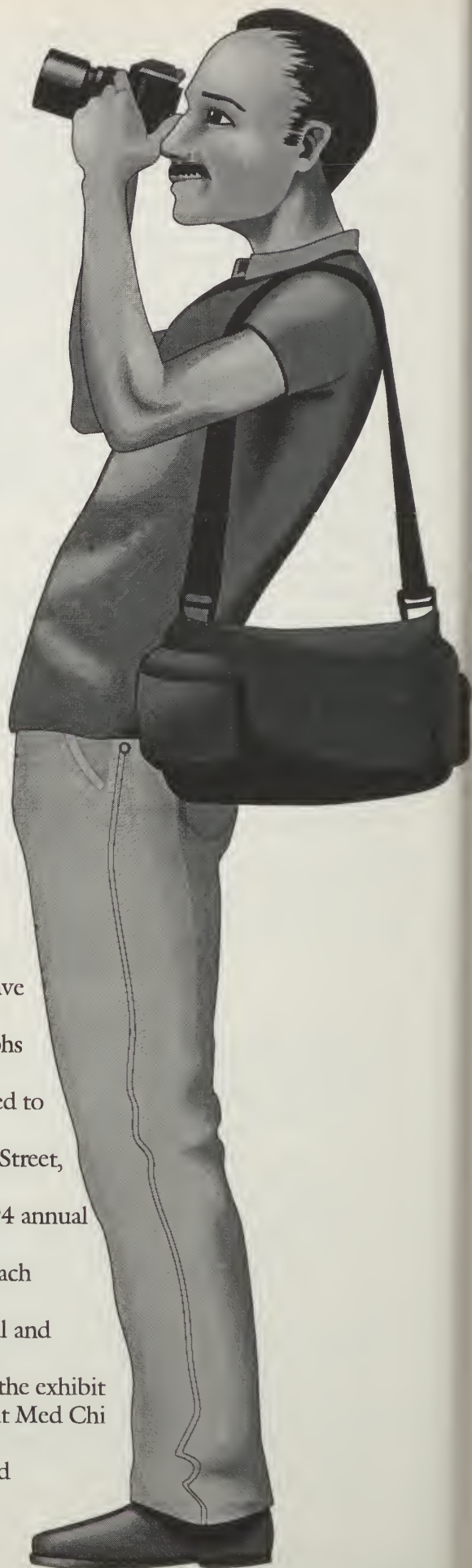
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The nature and status of drug abuse treatment

David N. Nurco, D.S.W.; Timothy W. Kinlock, Ph.D.; and Thomas E. Hanlon, Ph.D.

ABSTRACT: *This article focuses on the effectiveness of the major drug abuse treatment modalities (methadone maintenance, therapeutic communities, outpatient drug-free programs, and short-term detoxification) in the United States. It includes findings specific to individual clients and to particular modalities. Methadone maintenance, therapeutic communities, and outpatient drug-free treatment are generally effective in reducing illicit narcotic use and the criminal activity that often accompanies narcotic addiction. These effects are usually short-term, however, and more than one treatment episode is often required for long-term recovery. Longer time in treatment, pretreatment employment, and lack of pretreatment criminality are generally associated with favorable outcome regardless of modality. Issues needing further study, such as treatment for nonnarcotic (mainly cocaine) use, matching clients to treatments, and evaluating the cumulative effects of multiple treatment episodes, are discussed, along with the authors' research on the relationship between drug abuse, crime, and treatment in Maryland.*

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The major drug abuse treatment modalities available in the United States are methadone maintenance, therapeutic communities, outpatient drug-free programs, and short-term detoxification. These modalities have existed for nearly 30 years. They are offered to the general public at clinics and facilities supported, in part, by government health service contracts and by private resources. Other programs operate under the auspices of departments of correction for prison inmates, parolees, and probationers.

The most prevalent modality—methadone maintenance—is the most thoroughly studied.¹ There were approximately 80,000 methadone clients in the United States in 1989.² The major aim of methadone maintenance—exclusively designed to treat heroin addiction—is to provide compensating

medication (methadone) for heroin to stabilize everyday functioning and prevent physical withdrawal symptoms. Methadone maintenance treatment tends to continue longer than other treatment modalities, with many individuals staying in treatment for three years or more.²

Therapeutic communities are typically residential programs that use group pressure to eliminate reliance on drugs to solve personal problems. This modality emphasizes rigorous restructuring of an individual's attitudes and values to facilitate the assumption of personal responsibility. Many counselors in therapeutic communities are former substance abusers who were themselves rehabilitated in such communities. While varying by program and an individual's needs, the residential stay ranges from approximately 6 to 15 months.¹

Outpatient drug-free programs vary widely in treatment philosophy and duration. Unlike individuals in other treatment modalities, most clients of outpatient drug-free programs use nonnarcotic, rather than narcotic, drugs. Treatment duration is usually short, and clients are often referred to community agencies for health, mental health, vocational, and other services.¹

In short-term detoxification programs, which usually last fewer than 28 days, medication is used to relieve the symptoms of narcotic drug withdrawal. Detoxification programs under department of correction auspices also include client supervision and control.

Other treatment approaches include Narcotics Anonymous (NA), Cocaine Anonymous (CA), and self-help groups. With the exception of self-help groups, these programs have not been comprehensively evaluated.

Treatment effectiveness

Readdiction among treated narcotic addicts. Narcotic addiction is characterized by periods of remission and relapse.^{1,3-5} Many factors, including drug abuse treatment, account for remission periods. Readdiction usually occurs within the first three months following treatment^{1,3,4} and is often accompanied by increased criminal activity.^{5,6} An encouraging aspect of this phenomenon, however, is that crime and drug use are likely to decrease during treatment.^{7,8}

Comparisons of treatment modalities. An ambitious evaluation of treatment outcomes in the United States was the Drug Abuse Reporting Program (DARP), which, although not a randomized trial, involved over 4,000 clients.⁹ This research compared the effectiveness of methadone maintenance programs, therapeutic communities, outpatient drug-free treatment programs, outpatient detoxification clinics, and intake only (i.e., no treatment). Outcome measures included illicit drug and alcohol use, crime, and need for further treatment.

Results at three- to six-year follow-up clearly indicated that outcomes for methadone maintenance programs, therapeutic communities, and outpatient drug-free treatment programs

were superior to those for detoxification programs and intake only. Outcome among the three effective treatment approaches was not differentiated; all approaches markedly reduced self-reported narcotic use and criminal activity.

Regardless of modality, outcomes of treatments of under three months were generally poor. Also, individuals who were employed prior to treatment and who had committed fewer pretreatment crimes had more favorable outcomes.

Compulsory supervision with monitoring. Some encouraging findings of rehabilitation efforts involve legal pressure with a monitoring, or surveillance, component. In the DARP research, during-treatment performance, including longer program involvement and program completion, was positively associated with outcome. As in subsequent studies,¹⁰⁻¹² significant improvement among court-referred individuals tended to occur during the first 90 days of treatment, especially with methadone maintenance, suggesting a compliance factor associated with court-mandated entry and program surveillance. Following the initial marked change, improvement tended to continue over time as individuals developed the motivation needed to remain in treatment.

Three of the above studies¹⁰⁻¹² involved work by the Research Triangle Institute (RTI) with Treatment Alternatives to Street Crimes (TASC) programs. These studies consistently found that individuals under correctional supervision were more likely to remain in treatment longer than those who were not. Apparently, some individuals who are coerced into drug abuse treatment are changed by the experience or are, at least, dissuaded from engaging in destructive behavior during treatment.

In line with the above, studies by the California Civil Addict Program found that court-ordered, drug-free outpatient treatment accompanied by supervision (including urine testing and weekly visits to a parole officer) was associated with reduced narcotic use and crime.^{13,14} To measure the program's long-term effectiveness in reducing readdiction, a longitudinal study compared individuals in the civil commitment program requiring outpatient treatment and parole supervision with individuals released from the program early because of procedural errors. The two groups had similar baseline characteristics, and the average reporting period per subject was about 20 years. Although nearly all subjects became readdicted at some time after entry into the program, the treatment group had fewer instances of readdiction, and these readdiction periods were of shorter duration.⁷

Consistent findings

There are five salient findings on treatment outcome regardless of modality.

Length of time in treatment is related to outcome. The relationship between retention in treatment and favorable outcome is one of the most consistently documented findings

in treatment evaluation research. If an individual leaves treatment after a few days or weeks, it is unlikely that the intervention will permanently affect the person's behavior.

For example, in a review of over 100 studies on methadone maintenance effectiveness, McLellan reported that the few studies without methodological problems indicated that time in treatment was consistently among the major predictors of successful outcome.¹⁵ Subsequently conducted evaluations of methadone treatment—with fewer methodological weaknesses—yielded similar findings.^{2,11,12}

Comparable results have been reported for therapeutic communities. In a comprehensive literature review, DeLeon concluded that graduates of therapeutic communities have better treatment outcomes than dropouts, and that among dropouts, those who stay in the program longer have more favorable outcomes.¹⁶

Illicit drug use and criminal activity decreases during treatment. The longer individuals stay in treatment, the greater the reductions in frequency of criminal activity and drug abuse. Indications are that continuous participation in treatment for at least three months is needed to effect positive change. During-treatment reductions in crime and illicit drug use have been documented for individuals in methadone maintenance^{2,17} and therapeutic communities.^{16,18} Since crime rates are much higher during narcotic addiction periods than during nonaddiction periods,^{5,14,19–23} it appears that drug abuse treatment represents a reasonable crime reduction strategy for many addicts. However, such a strategy is not effective for all addicts, particularly those whose criminal and drug-abusing careers began at a relatively early age.

Criminally active individuals have poorer treatment outcomes. DARP investigators concluded that extensive criminal histories were the strongest and most consistent predictors of unfavorable outcomes, particularly illicit narcotic use, unemployment, and criminal involvement. More recently, Hubbard et al found that individuals who reported they had committed a predatory crime in the year before treatment had a higher incidence of committing predatory crime posttreatment.¹² Others have also indicated that individuals with extensive criminal histories have poorer treatment outcomes^{1,18,19} or avoid involvement in drug abuse treatment altogether.²⁴

Individuals with severe psychopathology have poorer outcomes. McLellan et al found that the severity of self-reported psychological problems at admission powerfully predicted outcome, including illicit drug use, criminal activity, and social and psychological adjustment.²⁵ Subsequent studies by these investigators showed that drug abusers with severe psychiatric symptoms are especially prone to early relapse.^{26,27} The researchers contend that a basic, global measure of psychiatric status is a rapid, reliable, and valid method of identifying clients requiring additional professional intervention.

Employed individuals have more favorable outcomes. As individuals become more involved with legitimate employment, they tend to become less involved with drug abuse. In an extensive review of drug abuse treatment, Kleber noted that job skills and employment are especially crucial if individuals are to remain drug-free.²⁸ Further, Simpson and Friend, analyzing 12-year follow-up data on 490 DARP clients, found that longer nonaddiction periods were associated with legitimate employment status.²⁹ The positive relationship between legitimate employment status and favorable outcome has also been observed elsewhere.^{30,31}

Findings specific to particular modalities

In contrast to the findings of consistency across modalities, which indicate uniform characteristics among treatment responders, the findings presented below focus on the specific characteristics of treatment modalities.

Detoxification. The DARP studies revealed that detoxification was not associated with long-term improvement. In his review of treatment effectiveness, Kleber noted that many individuals who begin a detoxification program do not complete the program or go on to longer treatment of another kind.²⁸ Also, many addicts simply use detoxification as a means of titrating their habits and of obtaining temporary relief from the stresses and demands of a higher dosage addiction.

Another factor contributing to the lack of long-term success of detoxification is its short duration, which may be as short as 3 days and is generally less than 28 days. This period is too brief to engender and solidify a commitment to a drug-free existence.^{3,9}

Methadone maintenance. Most individuals reduce their illicit narcotic use and criminal activity and improve their employment status while they are maintained on methadone.^{2,17,28} Compared with therapeutic communities, the methadone maintenance dropout rate tends to be lower;^{18,32} many methadone clients stay in treatment for at least three years.^{2,33} However, most individuals relapse shortly after treatment,^{13,28} which is a major reason why many individuals remain on methadone for many years.²⁸

Another problem associated with methadone maintenance is use of substances other than narcotics. While there is a reduction in illicit narcotic use during methadone maintenance treatment, nonnarcotic drug or alcohol use tends to continue and, at times, increase.²⁸ Increasing use of cocaine, in particular, by methadone clients has been well documented in recent years.^{6,34}

Therapeutic communities. As indicated by DARP and others, therapeutic communities are comparatively effective in reducing illicit drug use and crime and in improving employment status.^{1,9,16,18} Commonly reported advantages are the relative permanence of the treatment effects and client satisfaction with treatment.^{18,32} Further, Inciardi has indicated that

therapeutic communities are perhaps the most appropriate treatment modality in correctional settings in view of circumstances in the prison environment that make rehabilitation difficult.³⁵ Since therapeutic communities are isolated from the rest of the prison, they are protected to some extent from environmental influences that are counter to a stable, drug-free orientation.

In view of their highly demanding, confrontational approach, therapeutic communities have higher dropout rates than methadone maintenance programs.^{18,32} Therapeutic communities may not be appropriate for clients with severe psychological problems because of their confrontational style and strict prohibition of psychotropic drugs.³⁶⁻⁴⁰ For such clients, length of stay in a therapeutic community is generally associated with poorer, rather than better, outcome, in contrast to findings for all other client groups.

Drug-free outpatient treatment. This modality has the most diverse approaches, goals, services, and philosophy. In a recent literature review, Kleber indicated that the only features these programs have in common are that they do not dispense methadone and are not conducted in residential settings.²⁸ Many individuals who use this treatment modality are nonnarcotic, rather than narcotic, users. Comparative evaluations generally indicate that although drug-free outpatient programs are less effective in terms of retention, they are equally as effective as methadone maintenance or therapeutic communities with respect to longer-term outcome.^{9,37}

DeLeon indicated that determining drug-free outpatient treatment effectiveness is problematic because of the various approaches used.¹⁸ Kleber and Slobetz suggest that outcome may depend on the degree of client monitoring.³⁷ For example, the frequency of client-counselor contact varies considerably, and, over time, there is a tendency toward less contact. Kleber and Slobetz emphasized the need to carefully assess clients' needs in relation to program services and the availability of well-trained staff who can perform the various functions of the program despite limited client-counselor contact.

Treatment effectiveness issues

Evaluating cocaine treatment effectiveness. Traditionally, drug abuse treatment^{1,38} and drug abuse treatment research³⁹ have focused on narcotic (primarily heroin) addiction. Treatment for nonnarcotic and polydrug abuse is a more recent development.^{1,40} Among nonnarcotic drugs, cocaine commands the most attention in the treatment field because of increasing abuse rates in the general population⁴¹⁻⁴³ and among narcotic addicts.^{7,34,44}

Among the most common treatment services for cocaine abuse are group therapy, self-help, family therapy, pharmacological treatment, and individual counseling.⁴⁵ Although not specific to cocaine dependence, these services reflect the strategies currently practiced by most treatment agencies.⁴⁵ Diver-

gent philosophies linking specific interventions with stages of vulnerability, reactivity, and recovery cause the variations in approach.

While results of pharmacological and psychiatric treatment are encouraging,^{45,46} the findings are predominantly based on small samples and uncontrolled clinical trials. And, as is the case for heroin, relapse rates are high.⁴⁵ For example, Kosten et al found that only 22% of 232 cocaine-abusing methadone clients were abstinent from cocaine for at least 6 months during a 30-month follow-up period.⁴⁴ In addition, subjects who increased their cocaine use during follow-up had the most severe psychological, medical, and social adjustment problems.

Matching clients to treatments. A crucial issue in the drug treatment field is whether certain treatments work best for certain types of clients.^{18,28,33,40,47} Variables for client-treatment matching have been identified in addition to type and frequency of drug use.^{28,48-50} However, determining the effectiveness of matching clients to treatments is a complex issue.^{18,48} Since matching and random assignment to treatment are difficult because of methodological and ethical problems,^{1,18} there has been little progress in identifying the types of individuals that will benefit most from particular programs.⁵¹

Comprehensive multidimensional assessments of clients and treatment programs are needed to produce a good match. Assessment of clients' needs and problems using valid and reliable instruments is necessary. Treatment program assessment must consider basic features of a particular modality, as well as the services and types of staff available within a given program, since individual programs vary considerably within modalities.

Important client variables in client/treatment assignment are (1) the type, extent, and severity of drug use and criminal activity and (2) ethnic group and gender. These factors have been the subject of considerable research.

Type, extent, and severity of crime. Because drug abuse and crime are associated,^{35,47,52} the type, extent, and severity of a client's crime are relevant to treatment assignment, particularly when treatment involves surveillance. In examining a client's criminal activity, behavioral correlates of crime such as the precocity, persistence, and frequency of drug abuse, particularly narcotics and cocaine use, need to be considered because individuals with these characteristics are most likely to have been persistently involved in serious crime.^{47,53-55} Criminally active individuals tend to have poor treatment outcomes. Because of this and their tendency toward polydrug abuse, including the use of heroin or cocaine, such individuals are often recommended for programs with strict supervision and monitoring components, such as civil commitment. The strictest controls are needed for individuals who are persistently involved in violent crime, since they are the most difficult to manage and rehabilitate.⁴⁷

Ethnic and gender considerations. Treatment needs of drug abusers of different ethnic or gender groups vary considerably, and, therefore, members of these groups may benefit from different types of interventions. African-Americans and Hispanics have higher human immunodeficiency virus (HIV) seropositivity rates than do whites⁵⁶⁻⁵⁸ and are more likely to abuse cocaine, including intravenous cocaine.^{2,59} Whites, however, are more likely to abuse a greater variety of illicit narcotic and nonnarcotic drugs^{59,60} and to have more severe psychological symptoms.^{48,61} These ethnic-specific characteristics and drug abuse patterns have been observed in both men and women.

Men are more likely than women to commit crimes while in treatment;⁴⁸ however, women generally have more severe medical problems.^{62,63} Further, because female drug abusers are more likely than males to report injecting drugs, they are at higher risk for contracting and transmitting HIV.⁶³⁻⁶⁶ Female drug abusers are also more likely than males to need treatment services that include self-esteem building and parenting skills training.^{48,66}

Narcotic addict typologies. Our work on narcotic addict typologies indicates that addicts vary along many dimensions. Only by examining the kinds of narcotic addicts will treatment resources be more effectively used. By focusing on characteristics of individual addicts, counselors may be able to maximize the effectiveness of their efforts. For example, in one study,⁶⁷ we classified 460 addicts according to criminality, employment, and adequacy of income to meet needs. One type generated by this classification—the “successful criminal”—is accustomed to having more than enough money from illicit sources to meet needs. In contrast, the “working addict” is employed at least eight hours a day and is minimally involved in crime. Distinct treatment approaches are suggested for these two addict types.

Successful criminals are poor candidates for treatment that advises them to seek legitimate jobs paying far less than illegal activities. For such a strategy to be effective, these addicts would need to be closely monitored to determine whether they were returning to drug abuse and crime. If readdiction occurred, they would be referred back to the court for disposition. In contrast, working addicts, who attempt to live in both the drug and straight worlds, require more immediate reinforcement of their ongoing efforts at maintaining a legitimate lifestyle.

Evaluating the cumulative effects of multiple treatment episodes. Since many drug abusers have multiple and varied treatment experiences,^{1,3} distinguishing the effects of one particular treatment episode is difficult. The issue is further complicated since these episodes often involve different modalities or different levels of client receptivity to rehabilitation efforts. Research suggests, however, that the overall cumulative effect of multiple treatment episodes is positive.^{28,68,69}

Generally, progress in conquering drug abuse is slow, and intermittent periods of relapse are common. Ultimately, an addict's age may contribute to rehabilitation, since older individuals have better outcomes.¹

Over the long term, recovery may be facilitated by better matching of individuals to a particular treatment. Acknowledging the common problem of relapse among treated drug abusers, Kleber maintains that instead of producing despair, relapse should prompt a continued search for a better treatment for the individual in question.²⁸ He notes that there are already effective treatment methods in most cases, provided the right approach and the right person can be brought together.

Drugs, crime, and treatment in Maryland

We have conducted research on drug abuse (primarily narcotic addiction) in Maryland for over 25 years. Our research includes findings on the relationship between the frequency of narcotic use and rates of criminal activity among Baltimore areanarcotic addicts,^{19,23,53} as well as narcotic addict typologies.⁶⁷ Consistent with other research, our work has indicated that it is difficult to reduce use of narcotics permanently. Most narcotic addicts have at least one and, in most instances, several episodes of drug abuse treatment.^{47,50,53,67} Although during-treatment reductions in narcotic drug use and criminal activity are common, readdiction and increased criminal behavior often occur shortly after the treatment episode ends, regardless of modality.

In spite of these circumstances, we have uncovered some approaches that are likely to facilitate longer-term recovery. Because of the diversity among drug abusers, a comprehensive assessment of the client and the available treatment resources is necessary to maximize an intervention's effectiveness. Also, approaches such as self-help groups and positive social support may be useful. These approaches offer constructive alternatives to associating with drug abusers, which is a major cause of relapse to drug abuse and criminal activity.^{3,4,28,47} These approaches provide consistent contact with positive peer support; constructive, non-drug-oriented social and recreational activities; participation in conventional activities such as legitimate employment and outreach; and avoidance of contact with drug users.

Finally, improved treatment effectiveness can be more fully achieved through useful and timely application of research findings. Treatment program staff and policies must be kept current with new research developments to reduce the lag between knowledge and implementation.^{1,2} If these efforts can be applied within a network of treatment strategies tailored to address the problems, needs, and characteristics of individual clients, they have the potential to reduce drug abuse and the serious problems associated with it.

References

1. Anglin MD, Hser Y-I. Treatment of drug abuse. In: Tonry M, Wilson JQ (eds). *Drugs and Crime. Crime and Justice: A Review of Research*. (vol. 13). Chicago: University of Chicago Press. 1990; 393-460.
2. Ball JC, Ross A. *The Effectiveness of Methadone Maintenance Treatment: Patients, Programs, Services, and Outcomes*. New York: Springer-Verlag. 1991.
3. Leukefeld CG, Tims FM. An introduction to compulsory treatment of drug abuse: Clinical practice and research. In: Leukefeld CG, Tims FM (eds). *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. (NIDA Research Monograph #86). Rockville, Maryland: National Institute on Drug Abuse. 1988; 1-7.
4. Maddux JF, Desmond DP. *Careers of Opioid Users*. (Praeger Studies on Issues and Research in Substance Abuse). New York: Praeger. 1981.
5. Ball JC, Shaffer JW, Nurco DN. The day-to-day criminality of heroin addicts in Baltimore: study in the continuity of offence rates. *Drug Alcohol Depend* 1983; 12:119-42.
6. Hanlon TE, Nurco DN, Kinlock TW, Duszynski KR. Trends in criminal activity and drug use over an addiction career. *Am J Drug Alcohol Abuse* 1990; 16:223-38.
7. Anglin MD. The efficacy of civil commitment in treating narcotic addiction. In: Leukefeld CG, Tims FM (eds). *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. (NIDA Research Monograph #86). Rockville, Maryland: National Institute on Drug Abuse. 1988; 8-34.
8. Anglin MD, Brecht M-L, Maddahian E. Pretreatment characteristics and treatment performance of legally coerced versus voluntary methadone maintenance admissions. *Criminology* 1989; 27:537-57.
9. Simpson DD, Sells SB. *Evaluation of Drug Abuse Treatment Effectiveness: Summary of the DARP Follow-up Research*. (NIDA Treatment Research Report). Rockville, Maryland: National Institute on Drug Abuse. 1982.
10. Collins JJ, Allison M. Legal coercion and retention in drug abuse treatment. *Hosp Community Psychiatry* 1983; 34:1145-49.
11. Hubbard RL, Rachal JV, Craddock SG, Cavanaugh ER. Treatment outcome prospective study (TOPS): Client characteristics and behaviors before, during, and after treatment. In: Tims FM, Ludford JP (eds). *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects*. (NIDA Research Monograph #51). Rockville, Maryland: National Institute on Drug Abuse. 1984; 42-68.
12. Hubbard RL, Collins JJ, Rachal JV, Cavanaugh ER. The criminal justice client in drug abuse treatment. In: Leukefeld CG, Tims FM (eds). *Compulsory Treatment of Drug Abuse: Research and Clinical Practice* (NIDA Research Monograph #86). Rockville, Maryland: National Institute on Drug Abuse. 1988; 57-80.
13. Anglin MD, McGlothlin WH. Outcome of narcotic addict treatment in California. In: Tims FM, Ludford JP (eds). *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects*. (NIDA Research Monograph #51). Rockville, Maryland: National Institute on Drug Abuse. 1984; 106-28.
14. McGlothlin WH, Anglin MD, Wilson BD. Narcotic addiction and crime. *Criminology* 1978; 16:293-316.
15. McLellan AT. Patient characteristics associated with outcome. In: Cooper JR, Altman F, Brown BS, Czechowicz D (eds). *Research on the Treatment of Narcotic Addiction: State of the Art* (NIDA Treatment Research Monograph Series). Rockville, Maryland: National Institute on Drug Abuse. 1983; 500-29.
16. DeLeon G. The therapeutic community: Status and evolution. *Int J Addict* 1985; 20:823-44.
17. Senay EC. Methadone maintenance treatment. *Int J Addict* 1985; 20:803-21.
18. DeLeon G. Treatment strategies. In: Inciardi JA (ed). *Handbook of Drug Control in the United States*. Westport, Connecticut: Greenwood Press. 1990; 115-38.
19. Nurco DN, Ball JC, Shaffer JW, Hanlon TE. The criminality of narcotic addicts. *J Nerv Ment Dis* 1985; 173:94-102.
20. Anglin MD, Hser Y-I. Addicted women and crime. *Criminology* 1987; 25:359-97.
21. Anglin MD, Speckart G. Narcotics use and crime: A multisample, multimethod analysis. *Criminology* 1988; 26:197-233.
22. Ball JC, Rosen L, Flueck JA, Nurco DN. The criminality of heroin addicts: When addicted and when off opiates. In: Inciardi JA (ed). *The Drugs-Crime Connection*. (Sage Annual Reviews of Drug and Alcohol Abuse, Vol. 5). Beverly Hills, California: Sage. 1981; 39-65.
23. Nurco DN, Shaffer JW, Ball JC, Kinlock TW, Langrod J. A comparison by ethnic group and city of the criminal activities of narcotic addicts. *J Nerv Ment Dis* 1986; 12:297-307.
24. Johnson BD, Goldstein PJ, Preble E, et al. *Taking Care of Business: The Economics of Crime by Heroin Abusers*. Lexington, Massachusetts: Lexington Books. 1985.
25. McLellan AT, Luborsky L, Woody GE, O'Brien CP, Druley KA. Predicting response to alcohol and drug abuse treatments: Role of psychiatric severity. *Arch Gen Psychiatry* 1983; 40:620-25.
26. McLellan AT, Kushner H, Metzger D, et al. The fifth edition of the Addiction Severity Index: historical critique and normative data. *J Subst Abuse Treat* 1992; 9:199-213.
27. Woody GE, McLellan AT, Luborsky L, O'Brien CP. Sociopathy and psychotherapy outcome. *Arch Gen Psychiatry* 1985; 42:1081-86.
28. Kleber HD. Treatment of drug dependence: What works. *Int Rev Psychiatry* 1989; 1:81-100.
29. Simpson DD, Friend HJ. Legal status and long-term outcomes for addicts in the DARP follow-up project. In: Leukefeld CG, Tims FM (eds). *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. (NIDA Research Monograph #86). Rockville, Maryland: National Institute on Drug Abuse. 1988; 81-98.
30. Rounsaville BJ, Tierney T, Crits-Christoph M, Weissman MM, Kleber HD. Predictors of outcome in treatment of opiate addicts: Evidence for the multidimensional nature of addicts' problems. *Compr Psychiatry* 1982; 23:462-67.
31. Hubbard RL, Marsden ME, Rachal JV, Harwood HJ, Cavanaugh ER, Ginzburg HM. *Drug Abuse Treatment: A National Study of Effectiveness*. Chapel Hill, North Carolina: University of North Carolina Press. 1989.
32. Sorenson JL, Deitch D, Acampora A. Treatment collaboration of methadone maintenance programs and therapeutic communities. *Am J Drug Alcohol Abuse* 1984; 10:347-59.
33. Ball JC, Corty E. Basic issues pertaining to the effectiveness of methadone maintenance treatment. In: Leukefeld CG, Tims FM (eds). *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. (NIDA Research Monograph #86). Rockville, Maryland: National Institute on Drug Abuse. 1988; 187-91.

34. Kosten TR, Rounsaville BJ, Kleber HD. A 2.5 year follow-up of abstinence and relapse to cocaine abuse in opioid addicts. In: LS Harris (ed). *Problems of Drug Dependence* (NIDA Research Monograph #81). Washington, DC: US Government Printing Office. 1988; 231-36.
35. Inciardi JA. *The War on Drugs II: The Continuing Epic of Heroin, Cocaine, Crack, AIDS, and Public Policy*. Mountain View, California: Mayfield. 1992.
36. McLellan AT, Childress AR, Griffith J, Woody GE. The psychiatrically severe drug abuse patient: methadone maintenance or therapeutic community? *Am J Drug Alcohol Abuse* 1984; 10:77-95.
37. Kleber HD, Slobetz F. Outpatient drug-free treatment. In: DuPont RL, Goldstein A, O'Donnell J (eds). *Handbook on Drug Abuse*. Washington, DC: US Government Printing Office. 1979; 31-38.
38. Brown BS (ed). Foreword to the special issue of the International Journal of Addictions: Issues in clinical research and practice. *Int J Addict* 1985; 20:v-vi.
39. Hollister LE. Treatment outcome: Neglected area of drug abuse research. *Drug Alcohol Depend* 1990; 25:175-77.
40. Tims FM, Holland S. A treatment evaluation agenda: Discussion and recommendations. In: Tims FM, Ludford JP (eds). *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects*. (NIDA Research Monograph #51). Rockville, Maryland: National Institute on Drug Abuse. 1984; 167-74.
41. Abelson HL, Miller JD. A decade of trends in cocaine use in the household population. In: Kozel NJ, Adams EJ (eds). *Cocaine Use in America: Epidemiologic and Clinical Perspectives*. (NIDA Research Monograph #61). Washington, DC: US Government Printing Office. 1985; 35-49.
42. National Institute on Drug Abuse. Overview of the 1988 National Household Survey on Drug Abuse. Rockville, Maryland: National Institute on Drug Abuse. 1989.
43. Rouse BA. Trends in cocaine use in the general population. In: Schober S, Schade C (eds). *The Epidemiology of Cocaine Use and Abuse*. (NIDA Research Monograph #110). Rockville, Maryland: National Institute on Drug Abuse. 1991; 5-18.
44. Magura S, Siddiqi Q, Freeman RC, Lipton DS. Cocaine use and help-seeking among methadone patients. *Journal of Drug Issues* 1991; 21:617-33.
45. US Department of Health and Human Services. *Treatment Research*. (Reprinted from the Third Triennial Report to Congress from the Secretary, Department of Health and Human Services). Washington, DC: US Government Printing Office. 1991.
46. Gawin FH, Ellinwood EH Jr. Cocaine and other stimulants: actions, abuse and treatment. *N Engl J Med* 1988; 318:1173-82.
47. Nurco DN, Hanlon TE, Kinlock TW. Recent research on the relationship between illicit drug use and crime. *Behavioral Sciences and the Law* 1991; 9:221-42.
48. Kosten TR, Rounsaville BJ, Kleber HD. Ethnic and gender differences among opiate addicts. *Int J Addict* 1985; 20: 1143-62.
49. McLellan AT, Woody GE, Luborsky L, O'Brien CP, Druley KA. Increased effectiveness of substance abuse treatment: A prospective study of patient-treatment "matching." *J Nerv Ment Dis* 1983; 171:597-605.
50. Nurco DN, Shaffer JW, Hanlon TE, Kinlock TW, Duszynski KR, Stephenson P. Attitudes toward narcotic addiction. *J Nerv Ment Dis* 1987; 175:653-60.
51. Rounsaville BJ. Clinical assessment of drug abusers. In: Kleber HD (ed). *Treatments of Psychiatric Disorders: A Task Force Report of the American Psychiatric Association*. (Vol. 2). Washington, DC: American Psychiatric Association. 1989.
52. Inciardi JA. *The War on Drugs: Heroin, Cocaine, and Public Policy*. Palo Alto, California: Mayfield. 1986.
53. Nurco DN, Hanlon TE, Kinlock TW, Duszynski KR. The consistency of types of criminal behavior over preaddiction, addiction, and nonaddiction status periods. *Compr Psychiatry* 1989; 30:391-402.
54. Chaiken JM, Chaiken MR. Drugs and predatory crime. In: Tonry M, Wilson JQ (eds). *Drugs and Crime: Crime and Justice: A Review of Research*. (Vol. 13). Chicago: University of Chicago Press. 1990; 203-39.
55. Chaiken JM, Johnson BD. *Characteristics of Different Types of Drug-Involved Offenders*. Washington, DC: US Department of Justice. 1988.
56. Hahn RA, Onorato IM, Jones TS, Dougherty J. Prevalence of HIV infection among intravenous drug users in the United States. *JAMA* 1989; 261:2677-84.
57. Holmes KK, Karon JM, Kreiss J. The increasing frequency of heterosexually acquired AIDS in the United States. *Am J Public Health* 1990; 80:858-63.
58. Peterson JL, Bakeman R. AIDS and IV drug use among ethnic minorities. *J Drug Issues* 1989; 19:27-37.
59. Nurco DN, Kinlock TW, Hanlon TE, Ball JC. Nonnarcotic drug use over an addiction career—A study of heroin addicts in Baltimore and New York City. *Compr Psychiatry* 1988; 29:450-59.
60. Nurco DN, Wegner N, Stephenson P. Female narcotic addicts: changing profiles. *J Addict Health* 1983; 3:62-105.
61. Shaffer JW, Nurco DN, Hanlon TE, Kinlock TW, Duszynski KR, Stephenson P. MMPI-168 profiles of male narcotic addicts by ethnic group and city. *J Clin Psychol* 1988; 44:292-98.
62. Reed BG. Drug misuse and dependency in women: the meaning and implications of being considered a special population or minority group. *Int J Addict* 1985; 20:13-62.
63. US Department of Justice. Implications of the Drug Use Forecasting Data for TASC Programs: Female Arrestees. (Bureau of Justice Assistance Monograph). Washington, DC: US Department of Justice. 1991.
64. Hser Y-I, Anglin MD, McGlothlin W. Sex differences in addict careers. 1. Initiation of use. *Am J Drug Alcohol Abuse* 1987; 13:33-57.
65. Wish ED, Gropper BA. Drug testing in the criminal justice system. In: Tonry M, Wilson JQ (eds). *Drugs and Crime. Crime and Justice: A Review of Research* (Vol. 13). Chicago: University of Chicago Press. 1990; 321-91.
66. Wells DVB, Jackson JF. HIV and chemically dependent women: recommendations for appropriate health care and drug treatment services. *Int J Addict* 1992; 27:571-85.
67. Nurco DN, Shaffer JW. Types and characteristics of addicts in the community. *Drug Alcohol Depend* 1982; 9:43-78.
68. Simpson DD. National treatment system evaluation based on the Drug Abuse Reporting Program (DARP) follow-up research. In: Tims FM, Ludford JP (eds). *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects*. (NIDA Research Monograph #51). Rockville, Maryland: National Institute on Drug Abuse. 1984; 29-41.
69. Tims FM, Ludford JP (eds). *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects*. (NIDA Research Monograph #51). Rockville, Maryland: National Institute on Drug Abuse. 1984. ■



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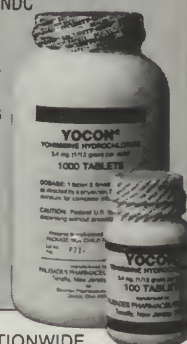
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Fitting the treatment to the problem: deciding where to refer substance abusers

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ABSTRACT: *The average physician sees a broad spectrum of substance-abusing patients whose illness levels may range from mild to severe. Considering the number and nature of substance abuse treatment options available, choosing the most appropriate treatment for any given patient may be confusing. This article provides workable guidelines for physicians based on a patient placement manual developed by the American Society of Addiction Medicine.*

Alcoholism is defined, in part, as “a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations.”¹ While definitions for other forms of chemical dependence are not as substantial, alcoholism and other drug dependence are treated similarly, particularly during rehabilitation. In treating all chemical dependence, physicians must consider attendant psychological, social, and environmental factors individually.

Initial considerations

Generally, treatment progresses under the following circumstances.

1. Medical or psychiatric conditions are stabilized promptly;
2. Patients abstain from psychoactive drugs, particularly sedatives; and
3. Patients' psychological and social health improves to the point that long-term abstinence can be sustained.

While it is important to treat the presenting symptoms, it is wise to treat active addiction as a priority. Except when an illness is deteriorating or life-threatening, physicians should delay medical or surgical treatments until the addiction has been addressed.

Psychiatric illness is often difficult to diagnose accurately in substance abusers, unless they have a clear history of illness pre-dating the addiction or are severely ill. Psychiatric illness is especially difficult to diagnose in

Table 1. Dimensions

| | |
|-------------|---|
| Dimension 1 | Acute intoxication or withdrawal potential or both |
| Dimension 2 | Biomedical conditions and complications |
| Dimension 3 | Emotional or behavioral conditions or complications |
| Dimension 4 | Treatment acceptance or resistance |
| Dimension 5 | Relapse potential |
| Dimension 6 | Recovery environment |

patients who are actively addicted and in those who are in the early abstinence phase of recovery.

Toxic brain syndrome induced by active chemical dependence can mimic other psychiatric illnesses. Usually, personality disorders cannot be considered primary until after a few months of abstinence. Diagnosing psychiatric illness should, therefore, be deferred until after the patient has stabilized. It is also important to revise tentative diagnoses as recovery evolves.

Matching treatment to the patient

The average physician sees a broad spectrum of substance-abusing patients with mild to severe illness levels. Considering the number and nature of substance abuse treatment options, choosing the most appropriate treatment for any given patient may well be confusing. To help physicians guide patients through treatment, the American Society of Addiction Medicine (ASAM) published a comprehensive guide to placement criteria for adult and adolescent patients entitled *Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders*.²

Placement in a particular treatment option is determined by matching illness severity to treatments of varying intensity and specialization. Problem areas serving as the bases for defining illness severity are referred to as "dimensions." The six dimensions by which severity is judged are listed in **Table 1**. Treatment options, separated into four levels of intensity, are shown in **Table 2**. These dimensions and treatment levels provide a specific means for determining the type and level of care a patient needs.

Decisions about levels of care (e.g., inpatient vs outpatient) are made by considering the severity of each dimension independently. Only a single dimension may need to be considered to select inpatient treatment, which is most often indicated in patients with active and severe medical or psychiatric illness.

Table 2. Treatment levels

| | |
|-----------|---|
| Level I | Outpatient treatment |
| Level II | Intensive outpatient treatment |
| Level III | Medically monitored intensive inpatient treatment |
| Level IV | Medically managed intensive inpatient treatment |

Dimension 1: Acute intoxication or withdrawal potential. This dimension addresses the patient's level of intoxication and likely response to withdrawal. A patient with a history of alcohol withdrawal seizures would be treated as an inpatient for alcohol detoxification. A patient with a history of severe depression during cocaine withdrawal would also be hospitalized during early withdrawal. An alcoholic patient with a history of uncomplicated alcohol withdrawal and an ability to return each day for assessment and counseling, however, would be a likely candidate for outpatient detoxification, including the monitored use of step-down dosing with a sedative.

Dimension 2: Biomedical conditions and complications. This dimension addresses biomedical conditions and complications and the degree to which they must be medically supervised and whether the conditions and complications are a result of, or independent of, the addiction. A patient with a complicating illness that can be treated on an outpatient basis would not require inpatient care unless his or her addiction requires inpatient care. However, patients with unstable or severe medical illness, such as decompensated cirrhosis, uncontrolled ketotic diabetes, or severe hypertension, would require hospitalization. Some illnesses may even take precedence over active addiction treatment until the patient's health is stabilized.

Dimension 3: Emotional or behavioral conditions or complications. Emotional or behavioral conditions or complications, whether primary or secondary to addiction, may require inpatient treatment and stabilization before the addiction can be treated intensively. It is likely that the addiction will require treatment at the same level of care as the emotional or behavioral condition.

The last three dimensions describe the addiction rather than a secondary or concurrent problem. Based on these criteria, a treatment level is chosen according to the severity of the addiction.

Dimension 4: Treatment acceptance or resistance. This dimension relates to the patient's denial or recognition of the consequences of active addiction; his or her understanding of the self-defeating nature of alcohol or drug use; and the degree to which the patient excuses and rationalizes substance use.

Dimension 5: Relapse potential. Potential for relapse is considered for those patients for whom medical or psychiatric illness is insignificant or has been stabilized. Relapse potential in such patients is judged by

- commitment to continued care;
- ability to follow a continued care program;
- gain made to date through previous treatment;
- degree of continued craving for alcohol or drugs;
- progress made in improving primary relationships, social integration, or ability to resume work; and

Table 3. American Society of Addiction Medicine adult patient placement criteria for the treatment of psychoactive substance use disorders*

| Criteria dimensions | Levels of care | | | |
|--|---|--|---|---|
| | Level I Outpatient treatment | Level II Intensive outpatient treatment | Level III Medically monitored intensive inpatient treatment | Level IV Medically managed intensive inpatient treatment |
| 1. Acute intoxication or withdrawal potential or both | No withdrawal risk | Minimal withdrawal risk | Severe withdrawal risk but manageable in Level III | Severe withdrawal risk |
| 2. Biomedical condition and complications | None or very stable | None or nondistracting from addiction treatment and manageable in Level II | Require medical monitoring but not intensive treatment | Require 24-hour medical, nursing care |
| 3. Emotional or behavioral conditions or complications | None or very stable | Mild severity with potential to distract from recovery | Moderate severity needing a 24-hour structured setting | Severe problems requiring 24-hour psychiatric care with concomitant addiction treatment |
| 4. Treatment acceptance or resistance | Willing to cooperate but needs motivating and monitoring strategies | Resistance high enough to require structured program but not so high as to render outpatient treatment ineffective | Resistance high enough despite negative consequences and needs intensive motivating strategies in 24-hour structure | Problems in this dimension do not qualify patient for Level IV |
| 5. Relapse potential | Able to maintain abstinence and recovery goals with minimal support | Intensification of addiction symptoms and high likelihood of relapse without close monitoring and support | Unable to control use despite active participation in less intensive care and needs 24-hour structure | Problems in this dimension do not qualify patient for Level IV |
| 6. Recovery environment | Supportive recovery environment or patient has skills to cope | Environment unsupportive but with structure or support patient can cope | Environment dangerous for recovery necessitating removal from the environment; logistical impediments to outpatient treatment | Problems in this dimension do not qualify patient for Level IV |

* Used with permission of the American Society of Addiction Medicine, Washington, DC.

- ability to accept, repair, and integrate adverse personal, social, or legal consequences of active addiction.

Dimension 6: Recovery environment. The recovery environment refers to the patient's circumstances including psychosocial support, support in the work place, housing, transportation, and skills in developing or expanding such supports.

A "crosswalk" developed by the ASAM integrates these dimensions with treatment levels (Table 3). The crosswalk succinctly and clearly presents how dimensions are used to determine treatment. The following case presentation illustrates how to use the dimensions in determining the level of care.

Case study

A 43-year-old married woman, mother of four, had a single 20- to 30-second grand mal seizure 20 hours after leaving a hospital recovery room following general anesthesia for a total hysterectomy. She had no previous history of seizure activity and was neurologically intact when examined by the attending physician one hour after the seizure. Her past medical history was not contributory. Her social history indicated she had one or two cocktails with her husband nearly every evening. Family history was not contributory, although her father had died from "liver disease."

Physical examination revealed a white female in no acute distress. The examination was within normal limits except as follows. Skin: Several bruises of recent origin on legs, hip girdle, and shoulder girdle. Abdomen: Intact surgical dressing. Neurology: Slight, fine tremor of fingers.

Laboratory data were as follows. A complete blood count (CBC) was within normal limits, except for the platelet count, which was 95,000, and the mean corpuscular volume (MCV), which was 101 fL. Serum chemistries were within normal limits except that AST (aspartate transaminase) was 190 U/L, ALT (alanine aminotransferase) was 145 U/L, GGT (gamma glutamyl transferase) was 405 U/L, and LDH (lactate dehydrogenase) was 105 U/L. Urinalysis results were within normal limits.

The patient entered the hospital the morning of surgery, was interviewed by the anesthesiologist, and was given preoperative medication. She tolerated the hysterectomy and immediate postoperative course without untoward events until the seizure. The patient's physician suspected alcohol withdrawal. He found her tremor more severe than preoperatively, but otherwise the patient was neurologically intact.

The physician reviewed her drinking history. She acknowledged with specific questioning that she drank daily, often six drinks, and the volume of drinks usually included three ounces of vodka. Further, her father had drunk heavily, and she believed his liver disease was alcohol-related. Telephone discussion with the patient's husband revealed that when he arrived home some evenings, he noted the odor of alcohol on his wife's breath and commented that she often continued to drink in the evening after he had stopped. He could not estimate the quantity. He doubted his wife was an alcoholic and thought that she only drank heavily on some days.

The physician stated that the patient's liver and blood cell damage indicated she was drinking heavily enough to cause harm to her body and that the tremor and seizure were related to alcohol withdrawal. The patient acknowledged she sometimes drank heavily, but did not think she had a problem. She tended to attribute her alcohol dependency to other persons and external events and seemed to require relief from involvement with her family members' problems.

The patient accepted treatment for alcohol withdrawal and was placed on decreasing doses of Librium (chlordiazepoxide HCl) for the next four days (Level III). By the second day, she was less anxious and tremulous. She accepted the need to discuss further a potential problem with alcohol and was discharged from the hospital with a prescription for two days of Librium dosing, which was to be controlled by her husband.

Discussion with managed care representatives of the patient's insurance company led to an agreement to place her in Level II, or adult partial hospitalization, to initiate rehabilitation. The following assessments contributed to this determination:

- No further risk for severe withdrawal syndrome (Dimension 1, Level I).

- No history or laboratory evidence of using psychoactive drugs other than alcohol (Dimensions 1 and 3, Level I).
- No physical or mental complications of addiction requiring medical or psychiatric hospitalization (Dimensions 2 and 3, Level I).
- No thoughts of homicide or suicide (Dimension 3, Level I).
- No evidence of personality disorder predating alcohol dependence (Dimension 3, Level I).
- Patient's need to distance herself from intensive involvement with family's problems and well-being. It was thought that the patient needed social reintegration and to extend her social contacts (Dimension 3, Level II).
- Patient's willingness to further consider the possibility of alcoholism. Her physician and care manager agreed that she required daily structured therapy (Dimension 4, Level II).
- Patient's tendency to attribute the cause of her alcohol dependency to other people and external events (Dimension 5, Level II).
- Husband and children supportive of recovery (Dimension 6, Level I).

While the patient seemed to require Level I care on a number of dimensions, Level II appeared to be called for on other dimensions. Accordingly, Level II care was chosen for the patient with the judgment that she needed treatment initially for about 20 hours a week for at least two weeks. Scheduling treatment during the evening—the time of her heaviest drinking—seemed sensible. The managed care representative acknowledged that she might subsequently need additional treatment or even inpatient treatment, depending on progress. Her physician agreed and thought inpatient rehabilitation would provide intensive treatment while also sequestering her from family and other potential relapse triggers until she became more emotionally stable.

The foregoing plan for treatment draws heavily on ideas from the dimensional admission criteria for a level of care as presented in ASAM's patient placement manual. The system works in the same way for all dimensions and levels of care. The 170-page manual, available from ASAM, provides workable and focused help in selecting treatment for patients, as well as a basis for agreement among health care professionals on necessary care levels.

References

1. Morse RM, Flavin DK. The definition of alcoholism. *JAMA* 1992; 268:1012–14.
2. Hoffmann NG, Halikas JA, Mee-Lee D, Weedman RD. *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*. Washington, DC: American Society of Addiction Medicine. 1991. ■

Where to refer patients who abuse alcohol or other drugs

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ABSTRACT: *Maryland has a rich diversity of substance abuse treatment programs. This article introduces some of the resources available to help physicians prescribe a workable treatment plan for their substance-abusing patients.*

Maryland has one of the most comprehensive regionally accessible networks of alcohol and drug abuse treatment programs in the nation. Indeed, the diversity of programs can prove confusing to physicians interested in guiding their patients through substance abuse treatment. Making a good referral for substance abuse treatment, however, should be no more complicated than referrals for other medical problems.

To prescribe a workable treatment plan, physicians need a good understanding of the types of treatment available in their area. Once grounded in the types of treatment, physicians may want to contact individual programs to establish a working relationship with people who staff the programs. This relationship can greatly facilitate communication and understanding between program personnel and physicians. The following information is a resource for Maryland physicians interested in enhancing their ability to appropriately refer patients for substance abuse treatment.

Treatment types

Detoxification. Detoxification is for withdrawal symptoms only and should not be considered a satisfactory treatment for underlying addiction. However, since detoxification is a prerequisite for entry into some addiction treatment programs, physicians must first determine whether patients need detoxification. It is not generally necessary for individuals who abuse marijuana or hashish, hallucinogens, PCP (phencyclidine), or cocaine.

Patients dependent upon alcohol, sedatives or hypnotics, or opioids, however, usually require detoxification prior to further treatment. Withdrawal from alcohol or sedatives or hypnotics can result in seizure and even death and must, therefore, be medically supervised. Opioid withdrawal,

while uncomfortable, is not life-threatening and can, in many instances, be treated on an outpatient basis.

Outpatient detoxification is a safe, effective, and low-cost alternative to inpatient detoxification for many patients. However, inpatient detoxification is indicated if a patient has delirium tremens, Wernicke-Korsakoff syndrome, seizure, disorientation, suicidal ideation, head trauma with accompanying loss of consciousness, or fever, or if the patient has failed at past attempts at outpatient detoxification.

Outpatient treatment. Outpatient treatment provides counseling services (usually group, individual, and family), advocacy, and social work case management in varying combinations to help substance abusers overcome the root cause of their addiction. *Intensive* outpatient treatment offers the same mix of services on a daily basis to effect an almost total immersion in counseling and rehabilitative efforts. The total immersion day-care format provides a respite from the settings and stresses that may have contributed to the initial addiction.

Residential treatment. Residential treatment programs provide housing in a sheltered, drug-free environment where an attempt is made to effect substantial, even radical, behavioral changes through ongoing counseling, group meetings, and confrontations. There is a near total removal from family and friends and the patients' prior environment for periods lasting 12 to 24 months.

Methadone treatment. Methadone clinics provide therapy for opioid (usually heroin) abusers. To replace their illicitly obtained, usually injected, opioid, patients are given an oral dose of the long-acting synthetic opioid, methadone. The methadone is dispensed daily and is accompanied by counseling services, advocacy, and legal and vocational rehabilitation services. Medical services are also often provided because of the many intravenous drug abusers who are positive for the human immunodeficiency virus (HIV).

Referral assistance

Physicians who need assistance or advice in referring patients for substance abuse treatment may contact the following:

- Addict Referral and Counseling Center (ARCC)
[Baltimore City agency]
410-366-1717
- Physician Rehabilitation Program
Medical and Chirurgical Faculty of Maryland
410-962-5580 or 800-992-7010
- American Society of Addiction Medicine (ASAM)
John Steinberg, M.D., president, Maryland Chapter
410-655-8594

Referral resources

The following resources are available for physicians interested in learning about local and national substance abuse treatment options.

- *Directory of Treatment Resources in Baltimore City*
Baltimore Substance Abuse Systems, Inc.
10 West Eager St., 2nd Floor
Baltimore, MD 21201
410-837-0905
- *Directory of Maryland Drug and Alcohol Treatment Programs*
Governor's Drug and Alcohol Abuse Commission
300 East Joppa Rd., Suite 1105
Towson, MD 21285
410-321-3523
- *Directory of Alcohol and Drug Programs in Maryland, 1993*
Maryland Alcohol and Drug Abuse Administration
Herbert R. O'Connor Building
201 West Preston St., 4th Floor
Baltimore, MD 21201
410-225-6886
- *National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs*
NIDA-NIAAA
5600 Fishers Ln.
Rockville, MD 20857
301-468-2600
- *National Directory of Certified Addictionologists*
American Society of Addiction Medicine
12 W. 21st St.
New York, NY 10010
212-206-6770
- Alcoholics Anonymous Hotline, 410-433-4843
- Narcotics Anonymous Hotline, 410-947-8028

Maryland treatment programs

The following list of treatment programs was compiled from information included in directories prepared by Baltimore Substance Abuse Systems, the Governor's Drug and Alcohol Abuse Commission, and the Maryland Alcohol and Drug Abuse Administration. Treatment programs are described in greater detail in those directories.

Allegany County

OUTPATIENT TREATMENT

- *Allegany County Health Department Outpatient Addictions Program*
301-777-5680
- *Family Therapy Services*
301-724-0471
- *Sacred Heart Hospital*
301-759-5071

RESIDENTIAL TREATMENT

- *Allegany County Health Department Joseph S. Massie Unit*, 301-777-2285
- *Lois E. Jackson Unit*, 301-777-2290

Anne Arundel County

HOSPITAL-BASED DETOXIFICATION

- *North Arundel Hospital*
410-787-4672

OUTPATIENT TREATMENT

- *Addiction Assessment and Rehabilitation Services*
Annapolis, 410-267-8377
Glen Burnie, 410-766-4357
- *Alcohol and Drug Programs Management, Inc.*
Annapolis, 410-266-8222
Glen Burnie 410-768-3303
- *Alcohol and Drug Recovery, Ltd.*
Annapolis, 410-266-8635
Annapolis, 410-280-2270
Glen Burnie, 410-768-3526
- *C.P. Health Services, Inc.*
410-224-4611
- *Creative Counseling Center, Inc.*
410-768-3921
- *DWI Assessment and Counseling*
410-721-0861
- *Greenspring Mental Health Services, Inc.*
410-266-9494
- *Health Management Enterprise*
410-266-0038

- *Hope House Outpatient*
410-987-0242
- *New Beginnings at Annapolis*
410-224-8657
- *New Life Addiction Counseling Services, Inc.*
Annapolis, 410-263-8590
Pasadena, 410-255-4475
- *Open Door*
Adolescents, 410-222-7121
Annapolis, 410-280-1244
Glen Burnie, 410-222-6725
Langley, 410-761-1070
- *Positive Alternatives*
410-263-8255
- *Psychological Services*
Gambrills, 410-721-9136
Severna Park, 410-768-8686
- *Recovery Resource Group*
410-787-0964
- *Renewal and Recovery Center of Annapolis*
410-224-3336
- *Jon M. Sherburn, L.C.S.W., B.C.D.*
410-266-8555
- *Stress and Health Management Center, Inc.*
410-647-0441
- *Substance Abuse Community Intervention*
410-222-7900

RESIDENTIAL TREATMENT

- *Hope House, Alcoholism Recovery, Inc.*
410-987-0242
- *New Beginnings at Meadows*
410-987-5344
- *Pathways*
410-573-5402
- *Second Genesis, Inc.*
301-656-1545

METHADONE TREATMENT

- *Anne Arundel County Health Department Open Door*
Annapolis/Parole, 410-280-1244
Langley, 410-761-1070

Baltimore City

HOSPITAL-BASED DETOXIFICATION

- *Francis Scott Key Medical Center*
410-550-0363
- *Maryland General Hospital*
410-225-8000
- *Mercy Medical Center Chemical Dependency Unit*
410-783-5860
- *Veterans Administration Drug Dependency Program*
410-962-3300

OUTPATIENT TREATMENT

- *Action Counseling Services*
410-539-5368
- *Addict Referral and Counseling Center*
410-366-1717
- *Archway Clinic*
410-550-1502
- *Baltimore Recovery Center*
410-962-7180
- *Bright Hope House, Inc.*
410-462-5510
- *Changing Point*
410-444-0400
- *Contemporary Counseling Services*
410-528-9333
- *Echo House Multipurpose Center*
410-947-1700
- *Family Service Foundation, Inc.*
410-333-6270
- *Francis Scott Key Medical Center Alcoholism Treatment Services*,
410-550-0032
Adolescent Treatment Program,
410-550-0149
Center for Addictions and Pregnancy,
410-550-3033
- *Harbel Substance Abuse Services*
410-444-2100
- *Harbor Mental Health Substance Abuse Program*
410-426-6380

- *Jewish Alcohol and Drug Abuse Services*
410-542-6300
- *Johns Hopkins Health System*
Alcoholism and Other Drug Dependencies, 410-955-5439
Comprehensive Women's Program, 410-955-5439
- *Jones Falls Community Corporation*
410-532-1770
- *Mountain Manor Treatment Center*
410-233-1400
- *New Beginnings—Hidden Brook*
410-837-7272
- *New Visions Counseling Center*
410-396-1141
- *Next Passage Drug-Free Substance Abuse Counseling Service*
410-362-7980
- *North Baltimore Center*
410-243-7078
- *Northwest Baltimore Youth Services, Inc.*
410-578-8100
- *Overcome Substance Abuse Program*
410-383-4982
- *Quarterway Outpatient Clinic*
410-233-0684
- *Sinai Hospital Substance Abuse Program*
410-578-5457
- *Total Health Care*
410-383-8300
- *Treatment Resources for Youth*
410-366-2123
- *Universal Counseling Services*
410-752-5525
- *University of Maryland Alcohol and Drug Abuse Outpatient Clinic*
410-328-6600
- *Veterans Administration Drug Dependency Program*
410-962-3300

RESIDENTIAL TREATMENT

- *Baltimore Recovery Center*
410-962-7180
- *Francis Scott Key Medical Center*
Alcoholism Treatment Services,
410-550-0032
Center for Addictions and Pregnancy,
410-550-3033

- *Mountain Manor Treatment Center*
410-233-1400
- *Quarterway Tuerk House*
410-233-0684

METHADONE TREATMENT

- *ADAPT Cares*
410-383-4900
- *Archway Clinic*
410-550-1502
- *Behavioral Pharmacology Research Unit*
410-550-0048
- *Daybreak Rehabilitation Program*
410-396-1646
- *East Baltimore Drug Abuse Program*
410-727-7400
- *Francis Scott Key Southeast Baltimore Drug Treatment Program*
410-550-0028
- *Glass Substance Abuse Program*
410-225-0594
- *Glenwood Life Counseling Center*
410-435-4565
- *IBR Mobile Health Service*
410-550-2460
- *Johns Hopkins Comprehensive Women's Program*
410-955-5439
- *Man Alive Research, Inc.*
410-837-4292
- *New Hope Treatment Center*
410-945-7706
- *Sinai Hospital Drug Dependency Program*
410-578-5355
- *University of Maryland Drug Treatment Center*
410-328-5154
- *Veterans Administration Drug Dependency Program*
410-962-3300

Baltimore County

HOSPITAL-BASED DETOXIFICATION

- *Franklin Square Hospital Center*
Dual Diagnosis Program
410-682-7756
- *Greater Baltimore Medical Center*
410-828-2302

OUTPATIENT TREATMENT

- *A.W.A.R.E.*
410-828-7388
- *Addiction Recovery and Related Therapies*
410-247-5792
- *Addictions Counseling Service*
410-833-5624
- *Alternatives*
410-583-2373
- *Awakenings Counseling Program*
410-764-5960
- *Baltimore County Health Department*
Baltimore, 410-687-6501
Dundalk, 410-887-7344
Lansdowne, 410-887-1000
Randallstown, 410-887-0624
Timonium, 410-887-7671
- *C.P. Health Services, Inc.*
410-363-3722
- *Catholic Charities Substance Abuse Counseling*
410-252-4000
- *Chesapeake Counseling Service*
410-682-4141
- *Clearview Mental Health Services*
410-547-1312
- *Community Counseling and Resource Center*
410-628-6120
- *Comprehensive Psychosocial Services*
410-764-7529
- *Dependency Recovery*
410-337-0999
- *Educational Resource Associates*
410-644-0616
- *Epoch Counseling Center*
Catonsville, 410-744-5937
Dundalk, 410-284-3070
Essex, 410-574-2500
Owings Mills, 410-363-8800
- *First Step Youth Services*
410-521-4141
- *Franklin Square at White Marsh*
410-682-7000
- *Greater Baltimore Medical Center*
410-828-2709
- *Greenside Psychological Associates*
410-628-0555

- *Greenspring Mental Health Services, Inc.*
410-823-0036
- *H.A.R.T.*
410-661-7200
- *Innovative Counseling and Rehabilitation*
410-825-3730
- *Judith P. Ritchey Center*
410-668-8000
- *Key Center for Human Services*
Arbutus, 410-792-9215
Dundalk, 410-284-5802
- *Metro Alcohol and Drug Abuse Services, Inc.*
410-597-8600
- *Mountain Manor—Baltimore*
410-282-3262
- *New Beginnings at Hidden Brook Family Center*
410-628-7272
- *New Beginnings Outpatient Center*
410-282-8238
- *New Life Addiction Counseling*
410-285-0736
- *New Waters*
410-788-3019
- *Recovery with Dignity*
410-494-8123
- *The Resource Group*
410-337-7772
- *S & S Counseling Service*
410-574-1850
- *Sheppard Pratt Health System Outpatient*
410-938-3000
- *TRW Associates, Inc.*
410-780-3555
- *Whitfield Associates*
410-825-0041

RESIDENTIAL TREATMENT

- *Sheppard Pratt Health System*
410-938-3000

METHADONE TREATMENT

- *Awakenings Counseling Program*
410-561-9591

Calvert County

OUTPATIENT TREATMENT

- *J. Russell Horton Associates*
410-855-1004

- *Calvert County New Leaf Counseling Center*
Chesapeake Beach, 410-257-1037
Prince Frederick, 410-535-5400
- *Calvert County Substance Abuse Program*
Barstow, 410-535-3079
Chesapeake Beach, 410-257-2585
Lusby, 410-586-1333

Caroline County

OUTPATIENT TREATMENT

- *Caroline County Health Department Counseling Center*
410-479-1882

Carroll County

OUTPATIENT TREATMENT

- *ADAPT Counseling, Inc.*
410-549-6282
- *Carroll County Outpatient Addictions Treatment*
Eldersburg, 410-795-7000
Westminster, 410-876-4410
- *Junction, Inc.—Westminster*
410-876-1788
- *Maryland Counseling Centers, Inc.*
410-831-7800
- *Mountain Manor—Westminster*
410-876-2425
- *New Life Addiction Counseling*
410-876-1336
- *Re-entry Mental Health Services*
410-848-9244

RESIDENTIAL TREATMENT

- *Shoemaker Center*
410-876-4845

METHADONE TREATMENT

- *Network Health Services, Inc.*
410-781-4158

Cecil County

OUTPATIENT TREATMENT

- *Cecil County Health Department Alcohol and Drug Center*
410-996-5106
- *Haven House Outpatient*
410-398-5868

- *TRW Associates/Elkton*
410-398-0010

Charles County

OUTPATIENT TREATMENT

- *Charles County Substance Abuse Services*
La Plata, 301-934-9021 or
301-934-4357
- *Changing Point South*
301-870-5100
- *Waldorf Counseling Services*
301-645-8869

RESIDENTIAL TREATMENT

- *Changing Point South*
301-465-9500
- *Jude House*
301-932-0700

Dorchester County

OUTPATIENT TREATMENT

- *Dorchester County Addictions Program*
410-228-7714

RESIDENTIAL TREATMENT

- *New Beginnings at Warwick Manor*
410-943-8108
- *New Beginnings at White Oak*
410-228-7000

Frederick County

OUTPATIENT TREATMENT

- *Allied Counseling Group*
301-698-7077
- *Frederick Counseling Center*
301-696-1950
- *Frederick County Health Department*
Adolescent, 301-694-1775
Adult, 301-694-1750
- *Guidelines Counseling Program, Inc.*
301-846-0967
- *Maryland Counseling Center, Inc.*
301-774-8801
- *Mountain Manor*
Emmitsburg, 301-447-2361
Frederick, 301-662-1407
- *White Flint Recovery, Inc.*
301-695-1212

RESIDENTIAL TREATMENT

- *Mountain Manor*
301-447-2361

METHADONE TREATMENT

- *Frederick County Health Department Program*
301-694-1750

Garrett County

OUTPATIENT TREATMENT

- *Garrett County Addictions Service*
301-334-8115

Harford County

HOSPITAL-BASED DETOXIFICATION

- *Fallston General Hospital*
410-879-0500

OUTPATIENT TREATMENT

- *Addiction Recovery and Related Therapies*
410-836-2551
- *Ashley Outpatient*
410-273-0305
- *Emmorton Treatment Program*
410-515-7510
- *H.A.R.T.*
410-893-8310
- *Harbor Mental Health*
410-561-3309
- *Harford County Health Department*
Bel Air, 410-638-3076 or
410-879-2404
Havre de Grace, 410-939-6722
- *New Beginnings at Bel Air Outpatient*
410-879-1919
- *Recovery with Dignity*
410-515-0220
- *TRW Associates*
Aberdeen 410-272-5454
Bel Air 410-879-4532

RESIDENTIAL TREATMENT

- *Ashley*
410-679-8992
- *New Beginnings at Hidden Brook*
410-879-1919

METHADONE TREATMENT

- *Harford County Drug Abuse Program*
410-879-2404

Howard County

HOSPITAL-BASED DETOXIFICATION

- *Taylor Manor Hospital*
410-465-3322
- *Howard County General Hospital*
301-740-7910

OUTPATIENT TREATMENT

- *C.P. Health Services, Inc.*
410-444-0400
- *Columbia Addictions Center*
301-730-1333
- *Greenspring Mental Health Services, Inc.*
410-964-6050
- *Howard County Health Department*
Columbia, 410-313-7500
Ellicott City, 410-465-0127
Laurel, 410-880-5889
- *Metro Alcohol and Drug Abuse Services*
410-381-0088
- *Oakview Treatment Center Outpatient*
301-740-8000
- *Orchard Hill Treatment Center*
410-730-5555
- *Psychological Health Associates*
410-461-2505

RESIDENTIAL TREATMENT

- *Changing Point*
410-465-7075
- *Oakview Treatment Center*
410-461-9922

METHADONE TREATMENT

- *Graham-Melvin Associates*
410-290-3906

Kent County

OUTPATIENT TREATMENT

- *Alternatives Substance Abuse Treatment Program*
410-778-7907

- *Counseling Resources, Inc.*
410-778-6286
- *Kent County Health Department Public House*
410-778-2616

RESIDENTIAL TREATMENT

- *Whitsitt Rehabilitation Center*
410-778-6404

Montgomery County

HOSPITAL-BASED DETOXIFICATION

- *Suburban Hospital*
301-530-2522

OUTPATIENT TREATMENT

- *Alcohol and Drug Education Counseling Center*
301-972-0013
- *Another Path—Rockville (Adolescents)*
301-251-4525
- *Circle Treatment Center*
301-654-1610
- *Counseling Institute of Suburban Maryland*
301-654-7021
- *Counseling Plus, Inc.*
301-933-3403
- *Counseling Services and Systems*
301-330-9198
- *D.A. Wynne and Associates, Inc.*
301-431-1911
- *Ethos Foundation*
Gaithersburg, 301-493-6447
Rockville, 301-671-5335
- *Family Therapy Institute*
301-984-5730
- *Guide*
Gaithersburg, 301-869-0094
Silver Spring, 301-529-1700
- *Kolmac Clinic*
Gaithersburg, 301-330-7696
Silver Spring, 301-589-0255
- *Maryland Counseling Centers, Inc.*
301-424-6955
- *Metro Alcohol and Drug Abuse Services*
301-598-9400

- *Montgomery County Adolescent and Family Therapy*
301-217-1430
- *OACES*
301-762-1383
- *Recovery Connection*
301-217-9853
- *Suburban Hospital Outpatient*
Bethesda, 301-530-2036
Rockville, 301-530-2036
- *The Healing Place*
301-963-7591
- *Turning Point*
301-738-1111
- *University Alcohol and Substance Abuse Program*
301-441-1818
- *White Flint Recovery*
301-294-6545

RESIDENTIAL TREATMENT

- *Avery Road Treatment Center*
301-565-7685
- *Melwood Farms Treatment Center*
301-924-5000
- *Second Genesis*
301-652-8662

METHADONE TREATMENT

- *Community Methadone Health Services, Inc.*
301-309-6966
- *Guide*
301-529-1700

Prince George's County

HOSPITAL-BASED DETOXIFICATION

- *Washington Adventist Hospital*
301-891-5577
- *Greater Laurel-Beltsville Hospital*
301-497-7980
- *Saint Luke Institute, Inc.*
301-967-3700

OUTPATIENT TREATMENT

- *Act II Counseling Services*
301-498-5766
- *Addiction Assessment and Rehabilitation Services*
Greenbelt, 301-423-0967
Suitland, 301-345-1200

- *Alcohol and Drug Recovery, Ltd.*
301-577-5255
- *Changing Point*
301-345-9181
- *Comprehensive Alcohol and Drug Counseling Services*
301-568-4447
- *Counseling Services, Inc.*
301-725-5616
- *Counseling Services Alternatives, Inc.*
Clinton, 301-599-0992
Riverdale, 301-454-0992
- *DARE Systems*
301-499-1834
- *Ethos Foundation*
College Park, 301-493-5447
Upper Marlboro, 301-948-2037
- *Family Service Foundation*
301-459-2121
- *Flynn/Lang Counseling Center*
301-725-1747
- *Guide Psychological Services*
301-779-7010
- *Holistic Counseling and Therapies*
301-792-2031
- *Institute of Life and Health*
301-567-7303
- *Key Center for Human Services, Inc.*
301-776-1814
- *Kolmac Counseling Center*
301-459-4647
- *Lifeline*
301-464-1030
- *C.A. Mayo and Associates, Inc.*
301-699-0344
- *Metropolitan Addiction Recovery Strategies*
301-423-0200
- *Prince George's County Health Department*
Bowie, Laurel, Riverdale,
301-864-1446
Cheverly, 301-386-0227
Clinton, 301-599-2231
Landover Hills, 301-386-1280
- *Reality House*
301-792-4080
- *Thomas Comprehensive Counseling*
301-585-2977

- *University Alcohol and Substance Abuse Program*
301-423-1216
- *Williams Center Addiction Treatment Services*
301-567-4693

RESIDENTIAL TREATMENT

- *Cheltenham Young Women's Treatment Program*
301-880-6875
- *Reality Quarterway*
301-792-4080
- *Second Genesis, Inc.*
301-652-8662

METHADONE TREATMENT

- *Alternative Rehabilitation*
301-731-9110
- *Prince George's County Health Department*
Cheverly 301-386-0227
College Park 301-345-1405

Queen Anne's County

OUTPATIENT TREATMENT

- *Alternatives Substance Abuse Treatment Program*
410-643-8652
- *Queen Anne's County Health Department*
410-758-1306

St. Mary's County

OUTPATIENT TREATMENT

- *Changing Point South*
301-373-3600
- *Relapse Prevention Education Center*
301-475-5741
- *St. Mary's County Health Department*
301-475-4300
- *Walden/Sierra Inc.*
301-863-6661

Somerset County

OUTPATIENT TREATMENT

- *Somerset County Health Department*
410-651-0822

Talbot County

OUTPATIENT TREATMENT

- *Alternatives Substance Abuse Treatment Program*
410-819-8226
- *Metro Alcohol and Drug Abuse Services*
410-598-0914
- *Talbot County Health Department*
410-822-4133

Washington County

OUTPATIENT TREATMENT

- *Addiction Specialist Associates*
301-739-3753
- *Functional Social Work*
301-791-3904

- *Washington County Health Department*
301-791-3243
- *Washington County Hospital*
301-582-3260

Wicomico County

HOSPITAL-BASED DETOXIFICATION

- *Peninsula General Medical Center*
410-543-7191

OUTPATIENT TREATMENT

- *New Beginnings—Salisbury*
410-548-2300
- *White Flint Recovery*
410-749-6422

- *Wicomico Addictions Center*
410-742-3784

RESIDENTIAL TREATMENT

- *Willis W. Hudson Center*
410-742-0151

METHADONE TREATMENT

- *Wicomico Addictions Center*
410-742-3784

Worcester County

OUTPATIENT TREATMENT

- *Worcester County Health Department*
Berlin 410-213-0202
Pocomoke City/Snow Hill
410-632-1100

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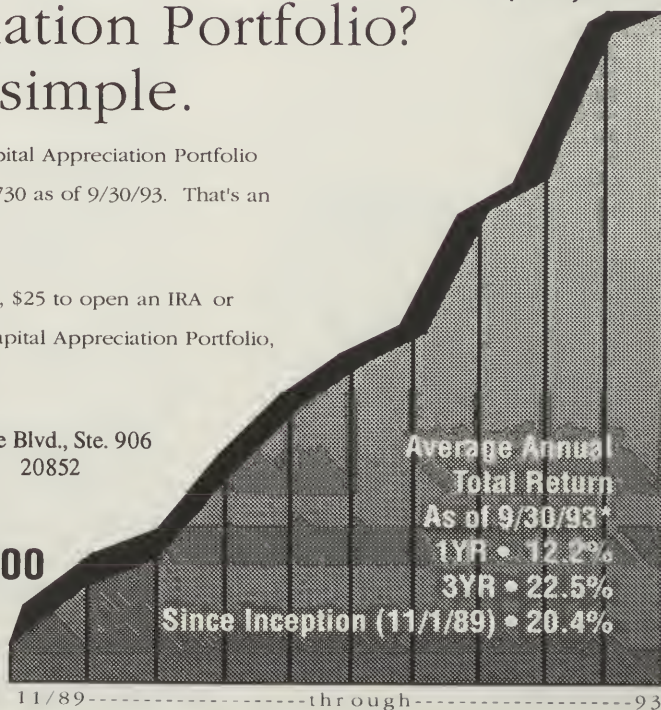
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WORD ROUNDS

Bart Gershen, M.D.

Faceless names

And if his name be George
I'll call him Peter
For new-made honor doth forget
men's names

Shakespeare

In a previous column I maintained that eponyms are not always obvious. For instance, in 1860, a German gynecologist reported a method for compressing the postpartum uterus to discharge the placenta. His name was Karl Sigmund Franz **Credé** and the maneuver is identified with his name, although many physicians are unaware of that derivation. A similar problem may occur when referring to **coudé** catheters. However, in this case, the word is **not** an eponym but derives from the French word for elbow. A **coudé** is a urinary catheter with a decided bend in it.

Another uncertain eponym, **Tourette's syndrome**, is a rare neurological disease presenting initially in childhood with facial tics, grimaces, choreiform movements, echomimesia, echolalia, and coprolalia. It was described in 1885 by George Edouard Albert Brutus **Gilles de la Tourette**, a neurologist at the famous Salpetriere Hospital in Paris.

Incidentally, Tourette's hospital was known as the **Salpetriere** because it had been built on the site of a former gunpowder storehouse used by soldiers of Louis XIII. **Salpetriere** means "saltpeter," or potassium nitrate, an essential ingredient in gunpowder.

Ghon's complex, is a calcified pulmonary lesion noted on chest x-ray. It was described in 1912 by Anton **Ghon**, a professor of pa-

thology at Prague University. (Ironically, Ghon died of tuberculous pericarditis in 1936.)

Pancoast's syndrome is characterized by shoulder and arm pain in the distribution of the ulnar nerve, **Horner's syndrome**, and a carcinoma of the superior sulcus of the lung. It was described by Dr. Henry K. **Pancoast**, who was the first physician in the United States to receive an appointment as a professor of radiology (University of Pennsylvania). **Horner** was a Swiss ophthalmologist who first described the ptosis, enophthalmos, and meiosis caused by a lesion on the cervical sympathetic nerves.

The syndrome of intrapulmonary hemorrhage, hemoptysis, and glomerulonephritis was described by Dr. Ernest **Goodpasture**. He graduated from Johns Hopkins University and for 30 years was professor of pathology at Vanderbilt University. Nonetheless, the eponymic origin of **Goodpasture's syndrome** often passes unrecognized.

In ischemic heart disease, a classic electrocardiogram (ECG) abnormality consists of upward bowing of the ST-T segment with inversion of the T wave. This is known as a **Pardee sign**, after Harold Ensign Bennett **Pardee**, a Manhattan cardiologist who described it in 1920.

(During World War I, **Pardee** collaborated with Sir Thomas Lewis in delineating the "soldier's heart syndrome," also known as neurocirculatory asthenia. This condition had originally been de-

scribed in American Civil War soldiers by Jacob Mendes **Da Costa**, and is often referred to as **Da Costa's syndrome**.)

Eponyms may originate from the names of places as well as people. The **Coxsackie virus** is an assorted group of enteroviruses named for **Coxsackie, New York**. This small town on the Hudson River lies just north of Catskill, New York. The virus was originally recovered from a patient who lived there.

Enteroviruses are those which reside primarily in the intestines. (From the Greek *enteron* 'intestine'.) Enteroviruses are a subgroup of **picornaviruses**, which also include the poliovirus and echovirus families. **Picornavirus** derives from the Spanish *pico* 'small', as in a **picosecond** (which is one trillionth or 10^{-12} seconds) plus **RNA** (since it contains ribonucleic acid) plus **virus**. Thus, a **picornavirus** is a very small, RNA-containing, virus.

The **poliovirus** is named for the disease it causes. **Poliomyelitis** is derived from the Greek *polios* 'gray', and *myelos* 'marrow', referring to the gray matter of the central nervous system that is infected by the virus. Ancient physicians believed that the brain and spinal cord were the marrow contained within the skull and vertebral column. The root *myelo-* also refers to bone marrow, as in **myelocyte**, **myeloma**, and **myelofibrosis**.

The **echovirus** is an acronym for enterocytopathic human orphan plus virus. The orphan status occurred because no human disease had been associated with the virus when it was initially discovered.

Epidemic **pleurodynia**, caused by a **Coxsackie B virus**, should be sus-

pected in patients with fever and pleuritic chest pain. Its viral agent was initially recovered in patients who inhabited **Bornholm**, a small Danish island in the Baltic Sea. Therefore, the eponymic **Bornholm's disease**.

The diminutive deer tick, *Ixodes dammini*, occasionally infects its human host with the spirochete *borrelia burgdorferi*. The resulting illness may start with a classic rash (erythema chronicum migrans) followed by severe—often crippling—arthritis, associated with occasional meningitis and myocarditis. The disease was first identified within a cluster of school children living in **Lyme, Connecticut**. Thus the eponym, **Lyme disease**.

Perhaps the greatest source of unrecognized eponyms may be found in the taxonomy of microorganisms. For example, Amedee **Borrel**, a French bacteriologist for whom the genus *Borrelia* was named, and Daniel **Salmon**, an American veterinarian, for whom the genus *Salmonella* was designated.

So, too, were *Escherichia*, *Brucella*, *Giardia*, *Klebsiella*, *Neisseria*, *Shigella*, *Nocardia*, *Wuchereria*, *Bordetella*, *Bartonella*, and *Listeria* derived, as follows:

- Theodor **Escherich** was a distinguished German pediatrician who discovered *Escherichia coli* in 1886.

- During a tour of duty on the island of Malta, Major-General Sir David **Bruce** discovered the bacterium responsible for undulant fever. It was also called Malta fever. (In cattle it is labeled **Bang's disease**, after a Danish veterinarian, Bernhard Laurits **Bang**.) The disease is also called **brucellosis**. Years later, while stationed in Zululand, Bruce discovered that the tsetse fly carried African sleeping sickness. (To-

day we know that *trypanosoma brucei rhodesiense* and *gambiense* are the infectious organisms.)

- Alfred Mathieu **Giard** was a famous 19th-century French biologist. The species name of *giardia lamblia* emanates from William **Lambl**, an Austrian physician, who first distinguished the causative agent in a patient with giardiasis.

- Theodor Albrecht Edwin **Klebs** was a German bacteriologist who discovered the diphtheria organism, also known as the **Klebs-Löffler bacillus**. Friederich **Löffler** was another German bacteriologist who first cultured the diphtheria organism. He should not be confused with the Swiss physician who described an eosinophilic pneumonia—William Loeffler.

- Albert Ludwig Siegmund **Neisser** was a German dermatologist who discovered the gonococcus.

- Kiyoshi **Shiga** was a Japanese bacteriologist who first described a bacillus that causes dysentery. In 1919, it was named for him.

- Edmond Isidore Étienne **Nocard** was the French veterinarian who first isolated the fungus that now bears his name.

- Otto **Wucherer** was the German physician who discovered the filarial parasite that causes elephantiasis. The species name of *wuchereria bancrofti* derives from Joseph **Bancroft**, a British physician, who had independently discovered the filarial organism.

- Jules Jean Baptiste Vincent **Bordet**, a Belgium bacteriologist and immunologist, discovered—together with Octave **Gengou**, a French bacteriologist—the organism responsible for whooping cough: the **Bordet-Gengou bacillus**, now named *bordetella pertussis*. In 1919,

Bordet received the Nobel prize in medicine.

● Alberto **Barton** was a Peruvian physician who discovered *bartonella bacilliformis*, the organism that causes Oroya fever.

● Baron Joseph **Lister** was a British surgeon who introduced aseptic surgery to the world.

And the list goes on. Eponyms unrecognized. Faceless names, no longer remembered. Like bloomers,

bikinis, and jerseys, people will continue to endow prosaic objects with proper names—subsidizing common idiom with quite uncommon sources. ■

The *Maryland Medical Journal* is the official publication of the Medical and Chirurgical Faculty of Maryland. It exists to serve Med Chi members' needs. The editorial board encourages members' participation, input, suggestions, and criticisms through submission of

- Original research, case studies, and review articles
- Essays on medical history in Maryland
- Updates on members' promotions, nominations, awards, and honors for inclusion in "Members in the News"
- Obituary information on Med Chi members for "In Memoriam"
- News of continuing medical education activities in Maryland for listing in "CME Programs"
- Opinions, questions, or thoughts about all aspects of medicine for "Letters to the Editor" and "Speak Out"
- Questions for "A Moment with Endocrinology and Metabolism"
- Radiologic puzzles for "Imaging Case of the Month"

COMING OUT OF THE DARK

Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

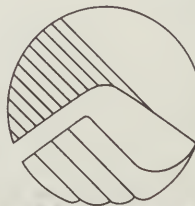
The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families.

The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201

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**Physician
Rehabilitation
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Book Reviews

A History of Public Health. George Rosen. Baltimore, Maryland: The Johns Hopkins University Press. 1993. 535 pages. \$18.95

The reissue of a 35-year-old book might occasion question about its release, but this apprehension will be relieved when the text is read, and one may appreciate the classic nature of the material and its presentation. The basic information has been garlanded by two superb additions—an introduction with first-rate, up-to-date references on George Rosen's text by Elizabeth Fee and an unexcelled biography of the author by Edward T. Morman.

A giant in the field of public health, Rosen approached the task of collation and composition as an experienced worker, educator, and author. His prose reflects the progressive nature of his left-wing political review; these socialist tendencies are evinced by his search for an existence in which the benefits of scientific and technologic advances would be made available to everyone.

Comprehensive and informative, the original text filled a void in the medical curriculum on the teaching of public health. Subsequent presentations by other authors have not diminished the luster associated with *A History of Public Health*.

The major health problems faced by humankind have related to community life—control of transmissible diseases, sanitation, provision of good water, and relief of disability and destitution. Solutions to these problems have led to the science of public health as it is now recognized.

Although Rosen starts his text with a brief account of events in ancient civilizations, he pays little attention to public health matters beyond the boundaries of Europe and North America. He does not limit his concept of public health, however, to disease control, but expands it to greater areas.

As in other fields of medicine, busy public health practitioners do not have the time and opportunity to follow all the current literature, much less read about the history of their specialty. This deficiency produces a loss of historical perspective between the scholastic erudite and the private practitioners deprived of the usefulness and joy of important preceding knowledge.

Cognizant of this situation, Rosen wrote the book primarily for physicians not associated with academia. Thus, the text serves as an information source for individuals who realize that public health is more than a collection of disciplines, bits of knowledge, and techniques, and who seek a larger perspective. The book also demonstrates to public health students that an unvarnished account of historical events devoid of science and statistics can provide insight on their own work.

In the 19th century, the administration of public health matters was confined largely to city and state health departments; few public health officers had any field experience. As the specialty grew in stature, it was oriented toward analyzing the controlling factors of health and disease on a population basis. The evolution of public health as a profession followed a strategic, albeit stumbling, course. Administrators were originally a unique mix of physicians, biochemists, engineers, and social science workers who, early on, served mostly in police and quarantine functions.

Public health difficulties were magnified intensely by the industrial revolution as each country witnessed the shift of people from farms to cities. The problems of crowding, filth, poor water supply, and horrible housing could not be ignored. Rosen more than adequately discusses the water supply, sewage disposal, epidemiological theory, maternal

and child health, occupational health, health education, public health administration, communicable disease control, medical care, statistics, public policy, and medical geography.

This book has much to offer students, physicians, and others interested in the practice of public health. The multiple bibliographies are exceptional, worthwhile sources of scholarly reference. The book, a welcome addition to the literary armamentarium of students and workers in the field, would be a fine addition to home, medical, and public libraries.

Joseph M. Miller, M.D.
Timonium, Maryland



Ethical Health Care Reform. Person-Focused Reorganization. Ignacio Ripoll, M.D. Norfolk, Virginia: Hampton Roads Publishing Company, Inc. 78 pages. \$8.95

When Faust benignly scolds Wagner, his famulus, in the opening pages of Goethe's play of the same name, Faust speaks of declamation by his attendant: "Paste your clippings together—but you'll never more invite the hearts of men, unless your own heart is behind it." Ignacio Ripoll may have been tremendously interested in his work, but much of what he writes consists of citations from other sources. He gives an admirable review of the literature but does not offer corrective suggestions or conclusions about his theme.

The difficulties besetting the health care industry are well known and the daily subject of national lay and medical professional concern. Ripoll believes the current system lacks integrity and that cost containment and the need to generate a profit has beclouded the true aim of the medical profession—the best possible treatment of the patient. The indi-

vidual problems of who will provide health care, what services will be employed, how such treatment will be delivered, and who will pay are problems apparent to the general public.

Ripoll's attempts to describe a way to restore wholeness to the system, improve the quality of attention, promote health, and decrease costs are praiseworthy but lack substance. He is convinced that the present system does not promote health care.

Ripoll reasons that a gross misuse of funds is happening and that medicine has stressed curing, usually in the end stages of disease, rather than preventing the onset of a disorder. He cites blatant examples: carcinoma of the lung and the high infant mortality rate. The cessation of smoking and proper prenatal care would save lives and tremendous sums of money.

The author points out that the duplication of resources by individual hospitals and hospital competition also cause financial waste. Extravagant procedures that delay death rather than prolong life contribute to the high costs of health care. Defensive medicine, too, increases expenditures sharply because physicians' fear of being sued results in the performance of many expensive and, sometimes needless, procedures.

The problem of high-cost health care is acute as 30 to 40 million Americans are without health insurance. Uncompensated treatment is a severe drain on hospitals' financial resources.

The focal points of an effective health care program would be cradle-to-grave care; equal access to care, with individuals paying proportionate amounts through copayments or deductibles; freedom of choice of physicians; easy enrollment; universal forms and a simplified billing system; and adequate compensation for physicians and hospitals.

Ripoll states that greater accent must be placed on preventive medicine including annual physical examinations, mammography and Pap smears, timely

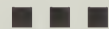
determinations of cholesterol, and vaccinations. These services must be buttressed by marked changes in the behavior of physicians, who must be ethically true to the system, more oriented to patient treatment, and more efficient. In addition, more reliable monitors must be instituted to assure that good changes result and stay in place.

The history of medical care since the 1930s is a mirror image of what Ripoll discusses. Integrity, empathy, and enhanced patient attention have been sought repeatedly through the creation of numerous alphabet agencies, each of which, in turn, has succumbed to the internal workings of that particular system. The high cost of medicine in the 1990s reflects the roller coaster economy. Inflation has become a malignant part of the health care system, necessitating a drastic cure.

Ripoll, although offering little help in this dilemma, has a background in academic internal medicine and is an associate professor at the Eastern Virginia Medical School. He is well qualified medically but not in administrative medicine on a national level.

Two main chapters and numerous subsegments present his thoughts about the emotional, physical, and moral costs to patients, relatives, medical staff, and administrators. The book reads easily, and the uninitiated may find much to ponder. But, in the main, little new is added for those seeking hard answers to a difficult problem.

Joseph M. Miller, M.D.
Timonium, Maryland



The Best of Medical Humor. Howard J. Bennett, M.D. (ed). Philadelphia: Hanley & Belfus, Inc. 1991. 228 pages. \$25.99

The interpretation of humor can be quite subjective. A nurse at the hospital often fills me in with the latest jokes. They can be hilarious or ho-hum, but much depends on the delivery and the reception. If she fires off three jokes in a row, I surmise that maybe she's worried about something. If I'm preoccupied with a sick patient or if I'm in a rush, the stories aren't so enjoyable.

The Best of Medical Humor is nicely delivered. It is published by a textbook producer in an attractive format. To improve its reception, select a time when you're not on call, when the beeper is turned off, and when the family is out at the mall. Then you can relish *The Best of Medical Humor*.

There are 13 chapters that can be read in any order. Much of the material is less than 30 years old, and many of the pieces are takeoffs, often poking fun at the restricted formality of technical writing in modern medical journals. Throughout, the writing is literate and never condescending—always expecting a high level of medical sophistication.

In praise of the book, the articles are all very readable. None is more than a few pages long. The chapter on "Academia,"

for example, contains seven items within 12 pages. Shorter items, such as letters to the editor, are nicely interspersed. The "Poetry" chapter is chock-full of small gems of wit. For example, page 81: *

*Multiple Authorship On
the NEJM Cover*

The outer front cover
May soon not provide
Enough space to list
all the authors inside.

Original articles
Should not as a rule,
Be authored by half
Of a medical school.

It is nice to give credit,
Where credit is due,
But on the front cover
Restrict it to two.

By Milton J. Chatton, M.D.,
Santa Clara Valley Medical
Center, San Jose, California.

Even if you're not in your favorite easy chair, this book is equally readable in the office, the den, or the bathroom. It would be good company on a vacation or at an out-of-town medical meeting. The "Appendix," with its additional journals and books of interest, is wonderful.

And now to quibble.... In his introduction, Dr. Bennett has explained his criteria for inclusion: *

In the final analysis, each selection had to fulfill two requirements. First, it had to say something about medicine, its clients, or its practitioners. And second, it had to make me laugh. Sometimes it was a deep, bellowing laugh like the ones reserved for Mark Twain or Woody Allen. At other times, it was the smile of recognition or a gentle laugh like the ones evoked by E.B. White or Garrison Keiller.

The most frequently reprinted author is Howard J. Bennett, M.D., with five bylines. Here is the subjective problem: Dr. Bennett makes himself laugh. I always found that comics such as Red Skelton and Sam Levinson were clever, witty, and funny, but that deadpan comedians such as Jack Benny and Groucho Marx made me laugh. Few of the pages of *The Best of Medical Humor* found me laughing out loud. The book might be improved by cartoons and some topical jokes or clever sayings (such as in *Reader's Digest*).

Any carping on my part should not keep you from buying the book. You will enjoy reading and later re-reading sections of *The Best of Medical Humor*. Even if I don't always bust a gut listening to the nurse's jokes, I always look forward to her performance. Like the book, it is one of life's pleasures.

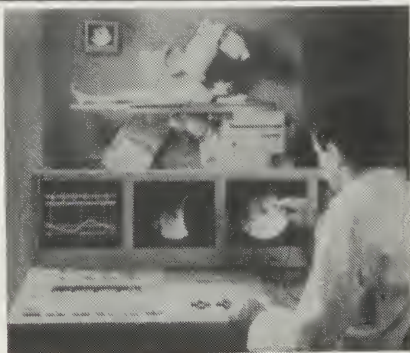
John W. Buckley, M.D.
Towson, Maryland ■

* Poem and text reprinted with permission of Bennett HJ. *The Best of Medical Humor*. Philadelphia: Hanley and Belfus. 1991.

Med Chi Bicentennial Celebrations

*Med Chi has already begun planning celebration activities for its bicentennial in 1999.
If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at
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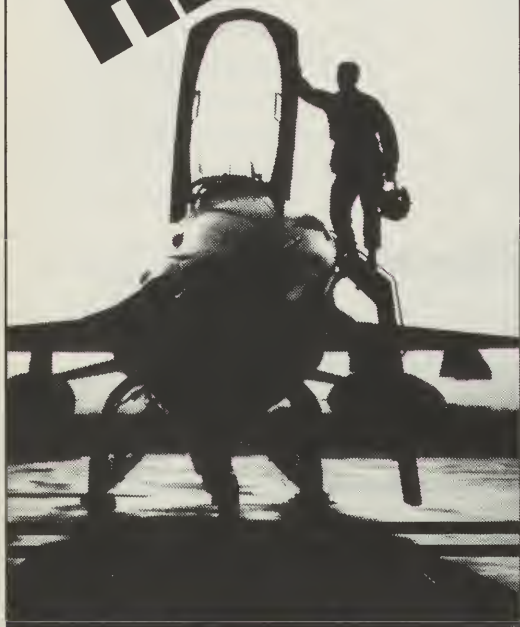
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Members in the News



NIEL BORRELLI, M.D., was recently elected president of the Board of Directors of the Carroll County General Hospital (CCGH) Foundation. In this position, he will be responsible for fund-raising activities including the planned 1.8 million dollar expansion of the emergency department scheduled to begin in March. Dr. Borrelli,

who strongly believes in physician involvement in hospital affairs, joined the CCGH medical staff 21 years ago. At CCGH, he has chaired the Department of Radiology, headed numerous committees, was elected medical staff president in 1987, and is currently senior attending radiologist. President of Carroll Imaging Associates, Dr. Borrelli is also active on the CCGH Golf Classic Participation Committee, whose annual event raised \$25,500 for the foundation last year.



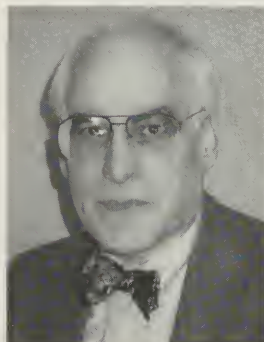
COLONEL LEONARD H. FLAX, M.D., was recently appointed the first chief surgeon of the State Defense Force Association of the United States (SDFUS). A Maryland native, Dr. Flax graduated from the University of Maryland School of Medicine, completed his surgical residency at Baltimore City Hospital and the Washington Hospital Center, and then

opened a private practice in general surgery. Colonel Flax began his military career as an operating room technician in the US Navy during World War II. He later joined the District of Columbia Army National Guard and was commissioned a lieutenant colonel with the specific mission of forming a Mobile Army Surgical Hospital (MASH) unit capable of rapidly bringing shock trauma techniques to the front lines. He was promoted to colonel and appointed commander of the 115th MASH, DC National Guard; his unit was among the first to be federalized for duty in Desert Storm. Colonel Flax was honored with the Outstanding Surgical Resident Research Award by the Washington Surgical Society for developing the Flax surgical drain. His military awards and decorations include the District of Columbia National Guard Certificate of Meritorious Service and Meritorious Service Medal.



NEAL M. FRIEDLANDER, M.D., was recently awarded the Baltimore City Medical Society 1993 Community Service Award for his efforts to improve the safety of the citizens of his neighborhood. A member of Citizens on Patrol in Bolton Hill, past president of the Mt. Royal Improvement Association, a

member of the Governor's Commission on Prison Health Care Reform, a member of the Board of Trustees of the Maryland Institute, College of Art, and chairperson of the Baltimore Police Department Advisory Council, Dr. Friedlander "exemplifies the best of the medical profession. He is a caring and concerned healer to his patients and a caring and concerned member of his community." Dr. Friedlander, who graduated from the University of Maryland School of Medicine, is also an attorney who earned his J.D. at Harvard Law School. An internist, Dr. Friedlander was appointed vice president of medical affairs at the Children's Hospital and Center for Reconstructive Surgery in October of 1993. Prior to that appointment, he was president of Mercy Medical Center medical staff. A clinical assistant professor of medicine at the University of Maryland medical school, Dr. Friedlander is also a member of the Board of Trustees of Mercy Medical Center, the Development Committee, and the Long-Range Planning Committee.



NORRIS L. HORWITZ, M.D., has been named vice president of medical affairs at Northwest Hospital Center. A graduate of Duke University, Dr. Horwitz received his medical degree from the Albert Einstein College of Medicine in New York City. He completed a residency at Cleveland Metropolitan General Hospital

and a fellowship in respiratory diseases at Johns Hopkins. Board certified in internal medicine and in pulmonary diseases, Dr. Horwitz has been an active member of the Baltimore County Medical Association, the Maryland and the American Thoracic Society, and the American Lung Association of Maryland. An instructor in medicine at the Johns Hopkins University

School of Medicine, he went to Northwest Hospital Center from Franklin Square Hospital Center, where he had been chief of the pulmonary medicine section since 1974. While at Franklin Square, Dr. Horwitz served as medical director of Respiratory Care Services and as director of the Medical Intensive Care Unit.



PAUL N. MANSON, M.D., was appointed a director of the American Board of Plastic Surgery. Known internationally as an expert in craniofacial fracture repair and rigid fixation, Dr. Manson has been professor and chief of the Division of Plastic, Reconstructive, and Maxillofacial Surgery at the Johns Hopkins Medical Institu-

tions since 1990. A graduate of the Northwestern University Medical School, he completed a general surgery residency at Fifth (Harvard) Surgical Service, Boston City and New England Deaconess hospitals, and a plastic surgery residency at Johns Hopkins in 1978. Dr. Manson is currently chairperson of the Johns Hopkins–University of Maryland Combined Plastic Surgery Program and director of plastic surgery, the Maryland Institute for Medical Services Systems Shock Trauma Center. A prolific author, he serves on the editorial boards of *Plastic and Reconstructive Surgery* and *Journal of Craniofacial Surgery* and has been a guest editor for *Annals of Plastic Surgery*. Dr. Manson, a member of the Baltimore City Medical Society and 30 other professional societies, has served as visiting professor or lecturer at medical schools, hospitals, and programs throughout the world.

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In Memoriam

Donald M. Barrick, M.D.

DONALD M. BARRICK, M.D., a general surgeon, died from lung cancer at his home in Timonium on January 7, 1994. A Washington native, he served in the US Air Force from 1951 until 1953, then graduated from the University of Maryland School of Medicine in 1962. Specializing in general and vascular surgery, Dr. Barrick opened a private practice in Baltimore that he continued until illness forced him to retire in 1992. A private pilot, Dr. Barrick also earned a law degree in 1984 from the University of Maryland and practiced with the firm of Seiland and Jednorski in Towson. In 1981, he was appointed chief of staff at the Maryland General Hospital, a position he held until his death. A longtime resident of Towson, Dr. Barrick is survived by his wife and three sons. He was 62.

Harry McBrine Beck, M.D.

HARRY MCBRINE BECK, M.D., a retired obstetrician and gynecologist, died of congestive heart failure, December 3, 1993, at his home in Pinehurst. A graduate of Johns Hopkins University and the University of Maryland School of Medicine, he served his internship and residency at Mercy Hospital in Baltimore. During World War II, he served in the 240th General Hospital Unit of the Army Air Corps in Europe, rising to the rank of major. In the late 1940s, Dr. Beck became chief of obstetrics and gynecology at Fort Meade General Hospital and joined the teaching staff of the University of Maryland School of Medicine. For seven years, he was chief of obstetrics at South Baltimore General Hospital. For eight years, he headed the obstetrics unit at Mercy Medical Center, where he was also president of the medical staff. Dr. Beck served on the staff of Greater Baltimore Medical Center, St. Joseph Hospital, Bon Secours Hospital, and the Lutheran Medical Center before retiring in 1987. Dr. Beck was a member of the Baltimore City Medical Society, the American Medical Association, the American College of Obstetrics and Gynecology, and the Maryland Obstetrics and Gynecological Society, for which he served as secretary-treasurer; he was also a diplomate of the American Board of Obstetrics and Gynecology. Dr. Beck was 79.

Arthur Bond Cecil, Jr., M.D.

ARTHUR BOND CECIL, JR., M.D., a general and thoracic surgeon, died May 11, 1993, in Easton. Dr. Cecil was a member of the medical staff of the Memorial Hospital at Easton, Maryland, Inc., from December

1952 until May 1993, serving as chief of surgery for a decade beginning in 1959. Recognized by his colleagues as an excellent general and vascular surgeon, he improved the quality of patient care through his devotion to education, his intellectual vigor, and his dedication to scientific progress. Appointed by the medical staff as director of continuing medical education in 1970, Dr. Cecil established and maintained the excellence of clinical grand rounds, "The Friday Morning Conference," and the hospital medical library from 1970 to 1993. In recognition of his countless hours of commitment and service to these efforts, the Cecil Award was established in 1983, and Dr. Cecil was its first recipient. A member of the Talbot County Medical Society and emeritus member of the Medical and Chirurgical Faculty of Maryland, Dr. Cecil had also served on the faculty of the Johns Hopkins University Department of Medicine, where he completed a surgical residency in 1943. Dr. Cecil was 79.

Nathan B. Hyman, M.D.

NATHAN B. HYMAN, M.D., a radiologist in Baltimore, died at his home, December 12, 1993, from cancer. A graduate of the University of Maryland School of Medicine, Dr. Hyman served as chief of radiology at Fort Belvoir, Virginia, from 1943 to 1946; he was discharged with the rank of captain in 1949. In 1952, he opened a private radiology practice which, after merging with two other radiology practices in 1961, became one of the mid-Atlantic's largest and most comprehensive radiology groups. For more than 30 years, Dr. Hyman was assistant professor in radiology at the University of Maryland and Johns Hopkins medical schools. Very active in Baltimore's Jewish community, Dr. Hyman also served as past president of the Maryland Radiological Society and was a member of the Baltimore City Medical Society and the American College of Radiology, to which he was named a fellow in 1977. Dr. Hyman was 72.

John A. Kehoe, M.D.

JOHN A. KEHOE, M.D., a member of the Prince George's County Medical Society, died December 26, 1993, at the Prince George's Hospital Center, from complications related to cancer surgery. A native of Pennsylvania, he earned a doctorate in statistical psychology from Catholic University. He taught at St. Thomas College during the 1930s and served in the US Army Air Forces during World War II. After the war,

he received a medical degree from the University of Chicago and taught at Loyola University in Chicago. He served his medical residency at US Public Health Service hospitals on Ellis Island and Staten Island in New York before moving to the Washington area. Dr. Kehoe practiced medicine in Cheverly and Riverdale, Maryland, from 1952 until shortly before his death. He was deputy medical examiner, then medical examiner, for Prince George's County during the 1960s and 1970s. During the late 1960s, Dr. Kehoe was chief of the medical staff at Prince George's Hospital Center and served on the board of directors in the early 1970s. Dr. Kehoe was 79.

William H. Mosberg, M.D.

WILLIAM H. MOSBERG, M.D., a neurosurgeon, died December 27, 1993, at Good Samaritan Hospital, after a long illness. A graduate of the University of Maryland School of Medicine, he spent two years as a captain in the US Army, serving in the European Theater of Operations. Dr. Mosberg completed his neurosurgical residency in 1949 and practiced neurology at the National Hospital in London, the Radcliffe Infirmary in Oxford, the Hospital de la Salpetriere in Paris, and Mercy Hospital at Loyola University in Chicago. He also worked in Asia and Egypt as a consultant to the US Department of Health, Education, and Welfare Office of Vocation Rehabilitation and taught in Southeast Asia, the Caribbean, and North Africa for CARE-MEDICO. He eventually returned to Baltimore where he had a private practice and taught neurosurgery at the University of Maryland. Author of 120 articles, Dr. Mosberg had served as editor-in-chief for *Clinical Neurosurgery*, and on the editorial board of three other medical publications. A member of the Baltimore City Medical Society, Dr. Mosberg was founding trustee of the Foundation for International Education in Neurosurgery, president of the Congress of Neurological Surgeons, and fellow of the American College of Surgeons and of the International College of Surgeons. In 1992, Dr. Mosberg received the American Association of Neurosurgical Surgeons Humanitarian Award. Dr. Mosberg was 73.

Edward Stephen Stafford, M.D.

EDWARD STEPHEN STAFFORD, M.D., died November 18, 1993, of pneumonia at Menno Haven Nursing Home in Chambersburg, Pennsylvania, where he had lived for 10 years. A graduate of Yale and Johns

Hopkins universities, Dr. Stafford served as chief of the surgical service for the 18th General Hospital in the South Pacific and India during World War II, rising to the rank of lieutenant colonel. From 1946 to 1977, he had a private practice in general and thoracic surgery. He also served as chief of the surgical service at Union Memorial Hospital in the late 1950s. A professor emeritus of surgery at the Johns Hopkins University School of Medicine, Dr. Stafford retired from Hopkins in 1977 after working there for 50 years; he had been assistant dean of the medical school from 1967 to 1971 and associate dean from 1971 to 1974. A prolific writer, he published more than 40 papers, co-authored a textbook, and served as managing editor of *The Bulletin of the Johns Hopkins Hospital* and *The Johns Hopkins Medical Journal* during the 1960s. Dr. Stafford was a member of the Baltimore City Medical Society, the American College of Surgeons, and the Southern Surgical Association. He was 87.

No additional information was available at press time for the following members;

Annie M. Bestebreurtje, M.D.

Baltimore City, November 11, 1993

Charles H. Conley, M.D.

Frederick County, November 6, 1993

John A. Dowling, M.D.

Montgomery County, December 5, 1993

Wolcott L. Etienne, M.D.

Prince George's County, December 21, 1993

Ephraim T. Lisansky, M.D.

Baltimore City, August 16, 1993

Peter N. Lombard, M.D.

Montgomery County, November 23, 1993

Michael S. Madeloff, M.D.

Montgomery County, December 31, 1993

Henry L. McCorkle, M.D.

Frederick County, November 14, 1993

Frank E. Poole, M.D.

Wicomico County, November 12, 1993 ■

Erratum

In "In Memoriam" in the November 1993 *Maryland Medical Journal*, Dr. Arthur B. Cecil's age was incorrectly listed. The *MMJ* regrets the error.

Auxiliary

Wicomico County AIDS Education Project

The Wicomico County AIDS Education Project began in the summer of 1988. The program's purpose is to educate teenagers about acquired immunodeficiency syndrome (AIDS). We originally targeted 7th to 9th graders, but have presented the program in various forms to students in the 5th through 12th grades.

The Auxiliary to the Medical and Chirurgical Faculty of Maryland was instrumental in initiating this project by suggesting that county auxiliaries develop AIDS education programs. Members of the Wicomico County Medical Society and the Auxiliary to the Wicomico County Medical Society worked together to implement this program. Physicians, nurses, teachers, artists, and public relations personnel from both organizations contributed their talents in formulating the content of the program, which includes the following:

- Definitions for human immunodeficiency virus (HIV) and AIDS are provided using posters as visual aids (Figure 1 and 2).

- The response of the white blood cells in the immune system to a cold virus and HIV are described using a felt board with white blood cell characters created by Richard Bird, M.D., a Wicomico County Medical Society member (Figure 3).
- How the virus is contracted is explained, along with a history of the disease that includes the names of famous people who have acquired it. (Figure 4).
- The 100% rule for prevention is emphasized (Figure 5). Condoms are discussed with students in grades seven and above. We relate Magic Johnson's advice from his video *Time Out*: "The safest sex is no sex."
- Current statistics are presented, with an emphasis on county, teen, and young adult numbers. (School nurses and health teachers are particularly appreciative of this information.)
- An optional movie from the American Red Cross for seventh grade and above, *A Letter From Brian*,

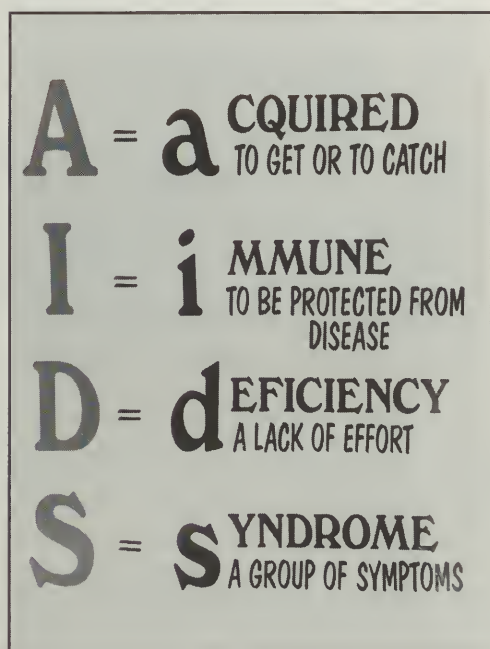


Figure 1. This poster uses mnemonics to help students understand AIDS.

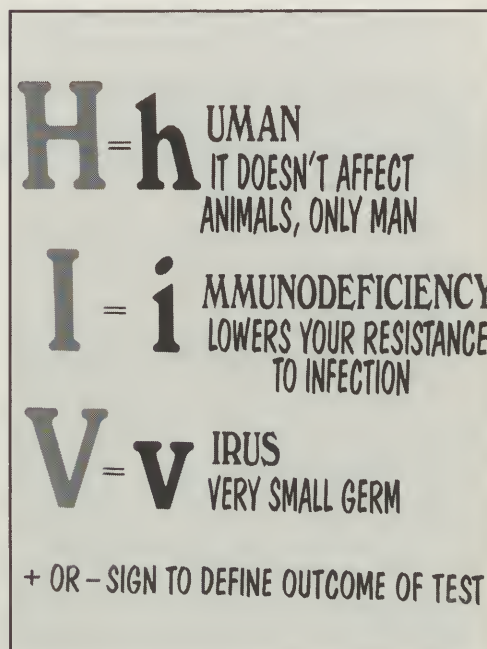


Figure 2. To ensure concepts are presented uniformly by all lecture volunteers, posters are provided as visual aids.



Figure 3. Dr. Richard Bird, a Med Chi member, designed white cell "characters" to help students visualize the immune system.

may be shown. The March of Dimes Birth Defects Foundation donated pamphlets on AIDS that are distributed to high school students.

- A question and answer period concludes the presentation.

Two interesting features of the education program are discussions about famous people with AIDS and the description of the immune system. Individuals mentioned include Arthur Ashe, Ryan White, Freddy Mercury, Magic Johnson, and Kimberly Bergalis. Discussing these people helps exemplify the different ways of becoming HIV positive.

The immune system's response to infections is explained by depicting a battle. This is how we tell the story to junior high students:

The surface of a cold virus contains antigens; "antigens" mean germs or something foreign to the body. Once this cold virus enters the blood, white blood cells react to the antigens on its surface. First, a white blood cell called a macrophage grabs the cold virus and identifies it. Then the macrophage activates the T4 cell, which is also called the helper T cell.

The T4 cell is like the general in an army. The general calls out the troops to fight the battle. These white blood cells include the killer T cell which can break down the virus, and the B cell. The B cell makes antibodies which are substances that can bind to the antigens on the surface of the virus and immobilize it so it can't do any harm in the body.

Then another T cell, called the suppressor T cell, stops the battle, and a memory T cell remembers what the cold virus looks like so when it enters the body again, it will be destroyed even faster.

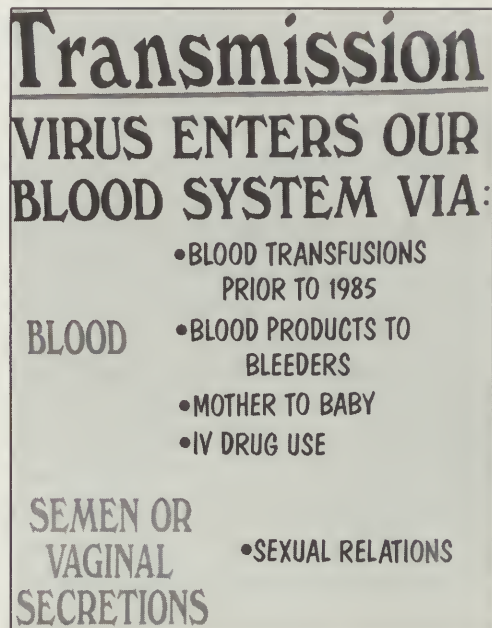


Figure 4. Simple text on posters helps reinforce the lecturers' description.

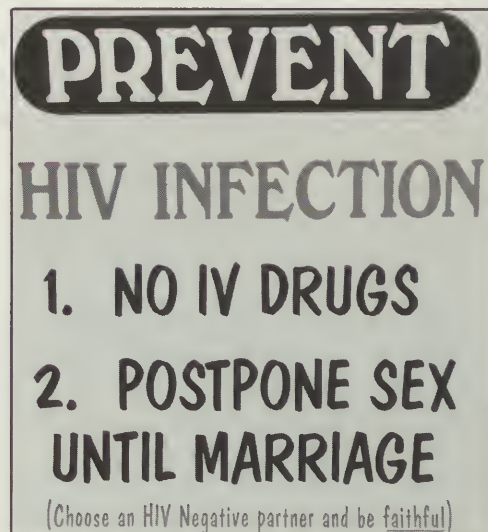


Figure 5. The program emphasizes the 100% rule.

AIDS is the only disease that disrupts the immune system so that it is helpless to destroy HIV and other germs. When HIV invades the body, the macrophage is activated to ingest the foreign antigen. Then the T4 is called.

The immune system's reaction to the HIV, however, is different. The clever human immunodeficiency virus hides inside the T4 cell so that the T4 cell is fooled and does not call out the troops. Once inside the T4 cell, the virus either remains inactive or it uses the T4 cell to make more of itself. If this process goes on rapidly, the T4 cell busts, releasing more human immunodeficiency virus to invade more T4 cells.

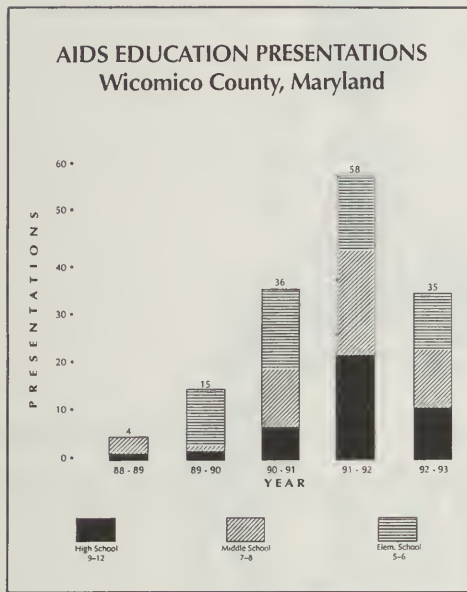


Figure 6. During the last five years, 148 presentations have been made to high school, middle school, and elementary school students.

Because the T4 cell function is altered by HIV, and because T4 cells are destroyed, the killer T cells are not called to aid in the fight against the invading virus. Some B cells do react to the HIV to make antibodies. The test for AIDS detects these antibodies.

The complete presentation, excluding the movie, can be given in less than an hour. From the questions the students ask, it appears that they have a good understanding of the material. The visual aids help keep their attention.

History of presentations

Figure 6 depicts the number and grade distribution of programs presented during the last five years. After perfecting the educational program in the first year, we presented it to Wicomico County educational personnel, including elementary school nurses and the health supervisor in the fall of 1989. They were enthusiastic about the project, requesting 15 presentations during the year, mostly to Wicomico County public school fifth graders.

In the fall of 1990, we sent letters to school nurses and middle and high school health teachers. This publicity effort more than doubled the number of presentations requested for the 1990-1991 year.

The 1991-1992 year was the most successful, with 58 presentations. We updated the presentation to include people in the news and newer scientific information.

Last year (1992-1993), we made 35 presentations. Reasons for the decrease include the availability of other

excellent AIDS educational tools, along with an increased knowledge about AIDS by school nurses, health teachers, and students, as well as a reorganization of the middle school health education curriculum.

Our audiences have included public and private school students and youth groups. In the public elementary schools, parental permission must be given for students to attend the presentation. The program has also been presented to students in Worcester and Somerset counties.

Five members of the Auxiliary to the Wicomico County Medical Society have made all the presentations, with about 90% of the presentations being given by the same two members. School personnel expect the lecturers to have a medical or scientific background. Because of the difficulty of some questions, lectures are always given by two volunteers.

Teachers and nurses pleased by our presentation have been our best references. We continue to think there will be a demand for this program because of its emphasis on the immune system, current statistics, and updated information. These features help teachers, nurses, and students stay current on this important issue.

**MARGARET W. SHENASKY, R.N., AND
JANE R. CORCORAN, M.S.**

Ms. Shenasky and Ms. Corcoran are co-chairpersons of the Health Education Committee of the Auxiliary to the Wicomico County Medical Society. ■

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For Your Benefit

AMA to Congress: Doctors must make medical decisions in a reformed system

Physicians are "deeply concerned" the Clinton administration and others proposing health system reform would turn medical decision-making over to insurance companies and government bureaucrats.

In a Nov. 5 speech to the Commonwealth Club of California, AMA EVP James S. Todd, MD, expressed this concern, adding that reform will not succeed if doctors go from being patient advocates to simple allocators of services.

The speech, scheduled for broadcast through National Public Radio on 150 stations in 37 states, was the Association's first public address since President Clinton submitted his health system reform bill to Congress Oct. 27.

Applauding the Clintons for setting the stage for system reform, Dr. Todd turned comments toward Capitol Hill, saying the AMA will work hard to convince Congress to approve a bill that does not compromise patient care or the trust of the physician-patient relationship.

"It's time to set the rhetoric aside and start looking at what we have to work with, and decide exactly what it is we must have and what we don't need," Dr. Todd said. "The medical profession has definite views on

how we think this process should unfold."

As the reform process turns to negotiations and compromise, Dr. Todd warned Congress that any plan calling for price controls, new layers of bureaucracy and overregulation will limit resources for patient care.

"Limits may be placed on the market forces that drive the kinds of vibrant competition we will need to sustain reform over a long period of time," he said.

Financing reform remains unclear, Dr. Todd said, adding any plan that relies heavily on Medicare and Medicaid cuts will threaten medical services for the poor and elderly "without providing the big bucks required to pay the bill."

He cited "the country's top economists," who warn that if anticipated savings fail to materialize, "it will trigger deep reductions in medical services and destroy the promise of reform."

To find a "common ground" on reform, Dr. Todd said "it is essential that the discussion be constructive and nonpartisan and that all players work together to move the country toward consensus."

AMA supports senator's move to end violence against women

Calling for tougher measures to end violence against women, the AMA supported the "Violence Against Women Act of 1993" during congressional testimony.

"We view this act as a strong step forward in recognizing and treating domestic violence as the public health epidemic it truly is," said AMA President-elect Robert E. McAfee, MD, to the Senate Judiciary Committee Nov. 12.

The act, introduced by Sen. Joseph Biden (D, Del.), is consistent with the AMA's initiative.

The Association has declared violence as a major health issue and supports research, educational programs and appropriate interventions to increase public awareness of domestic and other types of violence.

"Not only does domestic violence add enormous unnecessary expenses to health care costs in the U.S., the human costs are especially tragic and immeasurable," Dr. McAfee said.

He commended Biden for introducing the act, which would establish federal penalties for sex crimes and provide extensive grant dollars to combat crimes against women, including measures to prevent crimes in national and public parks and on public transportation.

The bill also would establish a national commission on violence against women.

It also would provide assistance to victims, improve access to shelters, authorize funding for safer campuses and provide additional training and education for judges and court personnel.

The Association, Dr. McAfee told the Senate Judiciary Committee, is very active on issues of family violence and violence against women, including organizing a national 4,000-member coalition of physicians against violence.

The AMA also developed and distributed diagnostic and treatment guidelines on child physical abuse, child sexual abuse, domestic violence and elder abuse.

On March 11-13, 1994, the AMA will sponsor the National Conference on Family Violence: Health and Justice, in Washington, D.C. The conference will focus on how the health care and justice systems can work effectively together to address family violence.

Dr. McAfee said the AMA will "work closely with the committee to provide our expertise" on violence and to explain how practicing physicians can be major players in preventing violence against women.

AMA raises computer record confidentiality issues before Congress

Computerizing patient records raises serious security and confidentiality concerns, the AMA told a congressional panel, urging it to consider voluntary efforts already being pursued by the medical profession.

The AMA testified Nov. 4 before the House Government Operations Committee, which is investigating confidentiality issues tied to computerization of medical records.

AMA Trustee Donald T. Lewers, MD, expressed the Association's views on the subject, saying "critical issues of privacy and confidentiality" become increasingly important as use of computer-based medical records expands and gains greater attention under system reform.

"The AMA believes any recommendations that are ultimately formulated for computerizing patient records should combine technological and practical patient concerns," Dr. Lewers said.

He urged the panel to consider the "high costs associated with security systems" and ensure "that records be easily accessible by health professionals."

"The need to protect patient confidentiality, record security and integrity must be balanced with the practical constraints of achieving perfect security or confidentiality," Dr. Lewers said.

We Need A Doctor In The House

When the Maryland General Assembly convenes in Annapolis for its 1994 session, the Medical and Chirurgical Faculty will be there. Since 1964, Med Chi has staffed the first aid facility operated during the 90-day legislative session. Come join us at the state capitol building, and see the laws being made first hand. One doctor a day is all that is needed to care for the public, the legislators, and their staffs. Take advantage of the opportunity to donate something priceless, your time.

Please detach the postcard located at the top of this page, fill it out and mail it. A confirmation card will be sent to you explaining the details. You will be carrying on a tradition established by the medical community for the people of Maryland.

Doctor of the Day 1994



Note: All Monday dates are evening sessions, beginning at 4:00 p.m. and ending at 5:00 p.m. For more information, call Joyce Yensen at Med Chi's Legal Department, 410-539-0872 or call toll free in Md. at 1-800-492-1056.

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Each of us must tell our state legislators that we, as citizens, won't let the tobacco industry determine our state laws. Just say "no" to the tobacco lobby. Call the State Board of Elections at 1-800-222-8683 to get your state legislators' names. If you know your legislative district number (from your voter registration card), call the Maryland General Assembly at 1-800-492-7122. Med Chi and I are asking you to make this call and share this notice with a friend.

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- Laws against selling tobacco to minors should be enforced, and tobacco sales licenses of those who repeatedly sell to minors should be suspended.
- Placement of tobacco vending machines should be limited.
- Employees and the public should be protected from secondhand smoke.
- Maryland should increase taxes on all tobacco products.
- Maryland should allow local governments to enact stronger tobacco control laws to protect the public. The tobacco industry knows that it can't fight the public on the local level where tobacco reform is always first and strongest. That is why the industry always tries to ensure that (weaker) state laws preempt the rights of city and county governments.

Add your name to our mailing list or phone tree by calling 410- 339-7108 or by writing to:
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The Coalition for a Smoke-Free Maryland

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The Auxiliary to the Medical and Chirurgical Faculty of Maryland
American Lung Association of Maryland
American Cancer Society, Maryland Division
American Heart Association, Maryland Affiliate
Maryland Academy of Family Physicians
The American Academy of Pediatrics, Maryland Chapter
The Maryland Congress of PTAs

Johns Hopkins University School of Hygiene and Public Health
The Maryland Association of County Health Officers
The Maryland State School Health Council
Advocates for Children and Youth
Maryland Group Against Smokers' Pollution
American Medical Women's Association, Branch I
Parent Action (of Maryland)
The Metropolitan Washington Public Health Association

Health Maintenance Organization Ambulatory Review Screens

Delmarva Foundation for Medical Care, Inc. (DFMC), as the PRO (peer review organization) for Medicare in Maryland, will use the following guidelines when performing the initial screening of physician office visit records in connection with their health maintenance review organization (HMO) Ambulatory reviews.

| Screens | Explanatory notes |
|---|---|
| 1. Medical record a. Legibility. b. Practitioner has signed notes and orders. | <p>The medical record should be clearly readable for accurate interpretation.</p> <p><i>If signature is not legible, standards of care state that initials are acceptable. Full signature or name stamp should be on at least one entry per progress note page; physicians must countersign nurses' entries. Physician assistants must write full name.</i></p> |
| 2. Baseline data a. Minimal personal and biographical data are recorded. b. Medical history and physical exam are recorded. c. Medical history and physical exam contain pertinent information. d. Medication allergies are listed or noted as "none." | <p>Baseline data could be developed over the course of several visits or at one initial visit.</p> <p>Personal and biographical data refer to information similar to hospital admittance data (generally nonmedical information): beneficiary name, date of birth, sex, etc. <i>Self-administered questionnaires are acceptable to obtain personal history and biographical data.</i></p> <p>Medical history and physical exam should be documented at the time of the first clinic visit or shortly thereafter.</p> <p>Documentation <i>may</i> include: age, height, vital signs (including blood pressure), past medical history (including immediate family), personal habits, preventive health maintenance, a complete physical examination, the ordering of appropriate diagnostic tests, procedures, medications, diagnostic impressions, and follow-up appointment, if necessary. <i>This information is based on the ability to collect the information at the time of the visit and if, in fact, the information is available.</i></p> <p>This information should be located in a recognizable place in the chart.</p> |
| 3. Visit data a. Chief complaint or purpose of visit and pertinent history are recorded. | <p>These seven questions refer to all visits, including specialty visits (e.g., orthopaedic, ophthalmology, gynecology, cardiology, ENT [ears, nose, and throat], general surgery, urology, dermatology).</p> <p>A chief complaint or purpose of visit as stated by the patient should be recorded. At least a brief history of current illness should be documented.</p> |

| Screens | Explanatory notes |
|---|--|
| <p><i>Visit data, con't</i></p> <p>b. Pertinent physical findings related to chief complaints or purpose of the visit is recorded.</p> <p>c. Current medications <i>and immunizations (if applicable)</i> are documented.</p> <p>d. Appropriate working diagnoses are listed.</p> <p>e. <i>The appropriate plan of treatment and its implementation are listed.</i></p> <p>f. <i>Follow-up instructions (including pertinent education) are recorded.</i></p> | <p>Appropriate physical exam related to the area of complaint(s) should be documented. <i>Visits for education, counseling, and other types of instruction are included as a purpose for a visit.</i></p> <p>They may be found in each visit note or on a medication record. <i>An ongoing list, noting any changes (additions, dosage changes, or discontinuations), is acceptable.</i></p> <p>A working diagnosis(es) should relate to the pertinent history of physical findings. Note: there does not have to be a specific coded diagnosis listed. A sign, symptom, or clinical impression is permissible in the absence of a proven diagnosis.</p> <p>The prescribed or planned treatment or medication for the current illnesses should be recorded. There should be evidence in the visit data of actual implementation (i.e., consult ordered and form on record). <i>At times, the only treatment may be observation.</i></p> <p>Appropriate and adequate instructions are to be indicated in the record when follow-up is necessary. The record should indicate if no further follow-up was needed.</p> |
| <p>4. Continuity of care</p> <p>a. The primary care physician or other involved practitioners were advised about, or followed up, all elements of inpatient hospital and any alternate health care setting discharge or follow-up plans.</p> | <p><i>Documentation of an attempt by the primary care physician to obtain and read the hospital discharge summary or other vital records should be present in the record regardless of whether or not the physician was the admitting physician. This will provide continuity of care by accurate collection of all pertinent data.</i></p> |
| <p>5. Consultation</p> <p>a. <i>Consultation process (including referral, evaluation, written report, and appropriate follow-up) was completed in a timely manner.</i></p> <p>b. <i>Chronicity of complaint resulting in adverse outcome (hospitalization or death).</i></p> | <p>A specific reason for referral should be documented in the patient visit notes or on a consultation referral sheet.</p> <p>The time lapse between the order for consultation and the actual consultation visit should be reasonable, according to the severity of the situation.</p> <p>Acknowledgment of consultant's report should be documented in the record.</p> <p><i>Failure to follow-up on a complaint requires referral to the physician.</i></p> |
| <p>6. Ancillary diagnostic and therapeutic services</p> <p>a. Laboratory test results are recorded.</p> | <p>All laboratory test results should be posted in the record. It is acceptable to have report results written in office visit data. <i>Documentation should include an actual lab report, not a phone report.</i></p> |

| Screens | Explanatory notes |
|--|--|
| <p><i>Ancillary diagnostic and therapeutic services,</i></p> <p>b. Laboratory test results are noted and addressed in a timely manner.</p> | <p>Laboratory tests were appropriately ordered as indicated by patient's condition.</p> <p>Significant abnormal test results are noted by the physician and follow-up is attempted. <i>Abnormal test results due to lab error or those that are of no concern due to patient's general condition, time of testing, etc., should be noted as such.</i> Documentation should show that the physician has seen and noted abnormal lab test results. Abnormal test results that are not noted (in a subsequent patient visit) by the physician, should be stated by the reviewer (e.g., elevated blood sugar). If the nurse reviewer is in doubt as to whether abnormality is sufficient to require medical intervention, refer to physician advisor. The physician advisor will then make a final decision.</p> |
| <p>c. A written interpretation of imaging services is signed by the reading physician and is present in the record for every study.</p> | <p>Q6 month profiles for chronic conditions are a minimum Medicare requirement. Medication monitoring, such as digoxin, lithium, diuretics, antidepressants, and anticoagulants, require more frequent monitoring. Failure to monitor this requires referral to the physician.</p> |
| <p>d. Results of imaging services are noted and addressed in a timely manner.</p> | <p>Any indication of underutilization should be noted and referred to a physician advisor.</p> |
| <p>e. Written interpretation(s) of electrocardiograms (ECGs) has been signed by a physician.</p> | <p>A written interpretation by a radiologist or the treating physician is present in the record. Radiologist's or attending physician's report should be in the record. This report should include a diagnosis or clinical impression.</p> |
| <p>f. ECG test results are noted and addressed in a timely manner.</p> | <p>X-rays were appropriately ordered as indicated by the patient's condition. X-rays should only be ordered for true diagnosis purpose.</p> <p>Abnormal x-rays are noted by a physician and followed up. Documentation should show that the attending physician has seen the x-rays or the report, noted any abnormalities, and acted upon them.</p> <p>ECGs should be interpreted and have interpreter's signature. <i>Typed reports are also acceptable.</i></p> <p>ECGs are appropriately ordered as indicated by the patient's condition.</p> <p>Abnormal ECGs are noted and follow-up attempted. Documentation should show that ECG abnormalities have been seen by attending physician and medical treatment initiated if the abnormality warrants it.</p> |

| Screens | Explanatory notes |
|--|--|
| 7. Preventive services a. Health plan-specific procedures for pneumonia prophylaxis, mammography, and Pap smear have been performed. b. Test results (mammography and Pap smear) are noted and addressed in a timely manner. | Procedures should be appropriate to patient's age and condition. <i>Refer to each individual HMO's preventive service guidelines.</i> There is evidence of patient referral when indicated by test results. There is evidence patient was appropriately treated as a result of referral. |
| 8. Education a. There is evidence of education <i>regarding health care issues specific to the patient's problem (e.g., smoking, elevated blood pressure, elevated cholesterol, obesity, ETOH [ethanol] abuse, domestic violence).</i> | <i>Evidence of counseling regarding the applicable health care issue(s) is documented.</i> |
| 9. Diagnoses and treatments for specific conditions | There is evidence that working diagnoses and chronic conditions are being treated appropriately or that the physician has determined that no treatment is currently required. |
| 10. Other significant findings | |

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral Street
Baltimore, MD 21201
410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

MMJ announcements for physician placements in the classified advertisements are charged at the regular classified advertising rate.

Maryland's Comprehensive Standard Health Benefit Plan

The following are excerpts of services covered by the proposed Comprehensive Standard Health Benefit Plan for Maryland. Beginning July 1, 1994, the Comprehensive Standard Health Benefit Plan must be offered by carriers (insurers and health maintenance organizations) that provide insurance to the small business market (2-50 employees).

Mental health and substance abuse

The plan provides 25 inpatient days yearly, with partial hospitalization traded on a two to one basis. Mental health and substance abuse share this one 25-day benefit period. Any such admission would be required to be preauthorized by the carrier.

Unlimited outpatient visits are covered subject to the following cost-sharing: 1-5 visits, carrier pays 80%; 6-30 visits, carrier pays 65%; 31 or more visits, carrier pays 50%.

Carriers must provide this service through a managed care environment. Essentially, a gatekeeper would have to approve a treatment plan for a particular individual. "Treatment for mental health and substance abuse not authorized in the treatment plan developed by the plan's designated provider or determined by the designated provider to be untreatable" will be exempted from coverage.

Health care providers

The carrier shall provide benefits for the covered services provided by health care providers licensed under the laws of the state and practicing within the scope of the license.

Inpatient hospital services

Unlimited coverage, including detoxification in a hospital or related institution, is provided.

Outpatient hospital services

The plan provides coverage for outpatient hospital services with a \$20 copayment or applicable coinsurance amount, whichever is greater.

Transplants

Bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants are covered.

General exclusions

Services and supplies that are not medically necessary are excluded.

A full copy of the proposed Comprehensive Standard Health Benefit Plan may be obtained by calling the Health Care Access and Cost Commission (HCACC) at 410-764-3460. The public may send written comments on this proposed plan to John M. Colmers, executive director, Health Care Access and Cost Commission, 4201 Patterson Avenue, 5th Floor, Baltimore, Maryland 21215. Comments must be received by March 7, 1994. ■

Revised 12/16/93 per Beth Sammis of the Health Care Access and Cost Commission

We're Fighting For Your Life.

WE'RE FIGHTING FOR
YOUR LIFE

American Heart
Association



The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the MMJ in the event that the work is published.

- **Manuscript preparation**—Manuscripts should be submitted to Editor, MMJ, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- **Permissions**—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the MMJ to reproduce the information/figure.

- **Editorial responsibility**—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

Accepted manuscripts become the permanent property of the MMJ and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset.

Miscellaneous meetings

- | | |
|---|-------------------|
| Advanced clinical cardiac electrophysiology , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | Feb. 9–11 |
| Advanced pediatric cardiac ultrasound , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | Feb. 16–18 |
| Update on management of adult HIV , sponsored by the Baltimore City Medical Society, at Union Memorial Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-652-0022. | Mar. 3 |
| Fourth Annual Dance Medicine Symposium , sponsored by Union Memorial Hospital and HealthSouth Spine Center, at Goucher College, in Towson, Maryland. Info: Andrea, 410-296-0511. | Mar. 5 |
| 30th annual scientific day—our patients suffer from reminiscences: memory and its role in clinical work , at Sheppard Pratt Conference Center, in Baltimore, Maryland. 6.25 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. | Mar. 12 |
| Ultrasound in abdominal surgery , at the George Washington University Medical Center, in Washington, DC. Info: Maria Gorrick, 202-994-1791. | Mar. 18 |
| Echocardiography for the sonographer , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | Mar. 24–26 |
| Monumental City Medical Society round table discussion , at Liberty Medical Center, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-652-0022. | Apr. 7 |
| Frontiers in ovulation induction , sponsored by the Washington University School of Medicine, in Philadelphia, Pennsylvania. Info: 800-325-9862. | Apr. 7 |
| Clinical psychopharmacology: review and update—1994 , at the Sheppard Pratt Conference Center, in Baltimore, Maryland. 6.25 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. | Apr. 22–23 |
| Challenge of improving health care in the city , sponsored by the Baltimore City Medical Society, at James Lawrence Kernan Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-625-0022. | May 5 |
| 46th annual meeting and scientific session , sponsored by the Maryland Academy of Family Physicians, in Ocean City, Maryland. 41.25 Cat 1 AMA/PRA credits; 41.25 AAFP prescribed hours. Fee: \$240 members; \$275 nonmembers; \$135 paramedics; free for residents, medical students, MAFP retired and life members. Info: Richard Colgan, M.D., 410-747-1980. | May 10–15 |
| Clinical auscultation of the heart , sponsored by the American College of Cardiology, at the Georgetown University Medical Center, in Washington, DC. 18 Cat 1 AMA/PRA credits. Info: 301-897-2695. | May 11–13 |
| Medical and Chirurgical Faculty of Maryland Annual Meeting at the Ramada Inn and Convention Center, in Hagerstown, Maryland. Cat 1 AMA/PRA credits available. Fee: Free for Med Chi members. Info: Joan Mannion, 410-539-0872 or 800-492-1056. | May 12–14 |
| Modern advances in the treatment of pain , sponsored by the Baltimore City Medical Society, at St. Agnes Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-625-0022. | June 2 |

Miscellaneous Meetings (continued)

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| Board review in family medicine , sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, in Arlington, Virginia. Info: Daniel Reichard, 202-994-4285. | June 11–15 |
| Psycho-economics: clinical psychiatry and health care reform in the 1990s , sponsored by the American Psychiatric Association, in Baltimore, Maryland. 34 Cat 1 AMA/PRA credits. Info: 202-682-6174. | Oct. 8–12 |

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month; 8:00–9:00 a.m. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, Maryland. Info: 301-279-6115.

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| Domestic violence | Feb. 10 |
| Sorting it all out | Feb. 17 |
| Tumor conference | Feb. 24 |
| Tumor conference | Mar. 10 |
| Comprehensive evaluation and management of sinus disease | Mar. 17 |
| Update on colon cancer | Mar. 24 |
| Migraines: new treatments, differential diagnosis of headaches | Mar. 31 |

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

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|---|-------------------|
| The cycle of sexual trauma: treating the victim and treating the offender. 18 Cat 1 AMA/PRA credits. Fee: \$300 physicians; \$275 groups of three or more on one check or credit card. | Feb. 10–12 |
| PET and SPECT imaging in oncology. 16 Cat 1 AMA/PRA credits. Fee: \$495 physicians; \$395 residents, fellows, and allied health professionals. | Mar. 9–12 |
| Diagnosis and treatment of neoplastic disorders. 14.5 Cat 1 AMA/PRA credits. Fee: \$325 physicians; \$150 residents, fellows, and allied health professionals. | Apr. 7–8 |
| Clinical care of the patient with HIV infection. 13 Cat 1 AMA/PRA credits; 12.75 AAFP credits. Fee: \$325 physicians; \$165 residents, fellows, and allied health professionals. | Apr. 7–8 |
| 21st annual pediatric trends. 41 Cat 1 AMA/PRA credits. Fee: \$650 physicians; \$450 residents and fellows. | Apr. 11–16 |
| Basic concepts in dysphagia diagnosis and management. Cat 1 AMA/PRA credits available. Fee: \$175 physicians; \$100 residents and allied health professionals. | Apr. 13 |
| Fifth multidisciplinary symposium on dysphagia. Cat 1 AMA/PRA credits available. Fee: \$400 physicians; \$225 residents and allied health professionals. | Apr. 14–15 |

The Johns Hopkins Medical Institutions (continued)

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| Biological response to orthopaedic implants. 12 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$125 residents and fellows. | Apr. 15-16 |
| Second symposium on the prevention of developmental disabilities in infants and toddlers. 14 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. | Apr. 18-19 |
| International conference on crystalline silica health effects: current state-of-the-art. Fee: \$450. | Apr. 18-20 |
| 35th annual postgraduate institute for pathologists in clinical cytopathology. Course A (home study). Preparation for Course B. | Mar.-Apr. |
| 35th annual postgraduate institute for pathologists in clinical cytopathology. Course B. 136 Cat 1 AMA/PRA credits. | Apr. 18-29 |
| Pediatric allergy and immunology for the practitioner. Cat 1 AMA/PRA credits available. Fee: TBA. | May 5-6 |
| Phototherapy and photochemotherapy. 10 Cat 1 AMA/PRA credits. Fee: \$250 physicians; \$200 nurses and technicians; \$150 residents and fellows. | May 6-7 |
| 21st century retina: what's hot, hype, and hard fact. 8 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$100 residents, fellows, and allied health professionals. | June 10 |
| Principles and practices of data management for clinical trials. Cat 1 AMA/PRA credits available. Fee: TBA. | June 16-17 |
| Advanced pediatric life support courses. 20 Cat 1 AMA/PRA credits; 18.5 AAFP prescribed hours; 20 AAP credit hours; 17 ACEP Cat 1 credits. Fee: \$525. | June 13-15 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27-30 |



PHYSICIAN'S RECOGNITION AWARD

During December 1993, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Ruben F. Ballesteros
Lillian B. McLean Beard
Stewart James Callis
Manuel B. Datiles

Selwa Jawad Diwani
John Glancy
Gerson Nathaniel Kaplan
Roland Robert Lee

Larry McGowan
Theodore P. Reed
Stephen Zachary Turney

The Johns Hopkins Medical Institutions (continued)

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.



"It's the personal service that keeps our patients coming back. Almost 20% of patients seen every week have been to Towson Imaging Center previously. They remember us when the time comes to have another diagnostic study done."

—Fouad E. Gellad, M.D.
Medical Director

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Charles and Beltway
Lutherville, MD 21093

Phone: (410) 825-3500
FAX: (410) 825-3509

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STRAIGHT Forward

INFORMATION

FOR AUTHORS

Straight Forward, a quarterly publication by the Physician Rehabilitation Committee of the Medical and Chirurgical Faculty of Maryland, informs Maryland physicians and other health care providers of developments in the areas of substance abuse, mental health, impairment, and recovery.

To accomplish this goal, the editorial consultants seek original informative or philosophical manuscripts on addiction, recovery, practice/patient management, and mental health. Calls for manuscripts on specific subjects will appear in future *Straight Forward* issues.

REQUIREMENTS FOR ARTICLES

1. Maximum length 2,500 words (about 10 double-spaced typed pages)
2. For references to other works within an article, cite the following information:
 - a. author(s),
 - b. complete title of work cited,
 - c. title of journal, publication, and publisher,
 - d. year of publication,
 - e. volume number,
 - f. first and last page number.
3. Submit two copies of the article, typed, double-spaced, with numbered pages and principal author's name on each page.
4. If possible, accompany the hard copies with an IBM-compatible WordPerfect disk (3 1/2" or 5 1/4").
5. A transmittal letter must accompany each submission and must contain the following elements:
 - a. the signature, full name, degree, title, and affiliation of the author(s);
 - b. a statement that the author(s) participated in forming the concept and drafting the article and take responsibility for its content and accuracy;
 - c. a statement granting *Straight Forward* copyright if the article is accepted for publication.

For a copy of a transmittal letter to which you can add information specific to your article, call 410-962-5580 or 1-800-992-7010.

Send submissions to *Straight Forward*
1204 Maryland Avenue
Baltimore, MD 21201

The managing editor will acknowledge receiving your submission immediately, and will notify you of its status for publication as quickly as possible, generally within a month. Thank you for your interest in *Straight Forward*.

The editorial consultants currently seek articles on the following topics:

- substance abuse issues specific to anesthesiologists,
- stress inherent in transitions in medical practice, for example, in opening a practice, in changing specialty, in preparing for retirement.

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Ebenezer Israel, MD, MPH - Director
Epidemiology & Disease Control Program

EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

January, 1993

Lifestyle and Chronic Disease

This is the second of two articles about chronic disease in Maryland. The first article was published in the December issue and focused on smoking.

Individual behaviors that increase the risk of chronic diseases and the probability of dying before age 65 years have been associated with coronary heart disease (1st among the leading causes of death), cancer (2nd), accidents (3rd), cerebrovascular disease (4th), chronic obstructive pulmonary disease (6th), diabetes (7th), and AIDS (10th). In Maryland, 37% of all deaths are caused by cardiovascular and cerebrovascular disease, followed by cancer (26%); among persons who died before age 65 years, these diseases accounted for a total of 51%.⁽¹⁾

Since 1986, the Maryland Department of Health and Mental Hygiene (DHMH) has conducted annually the Behavioral Risk Factor Survey (MD BRFS)⁽²⁾. This is a telephone interview which inquires about personal behaviors known to be associated with morbidity and mortality due to disease. The questions are intended to measure the presence of risk factors, such as self-reported diabetes, hypertension, high blood cholesterol, drinking and driving, smoking and no screening for cancer. Other questions capture examples of "healthy living" or health promotion. These include exercise, diet, weight, use of safety belts, nonchronic alcohol use, and

cancer screening tests such as Pap Smears and mammography.

In Maryland, as well as nationally, a large number of deaths are attributable to these risky behaviors. The most important risk factors are smoking, poor diet, lack of exercise and excess alcohol. Together, they account for an estimated 38% of all deaths (3). Table 1 shows the number of deaths attributable annually to each factor in Maryland.

Table 1

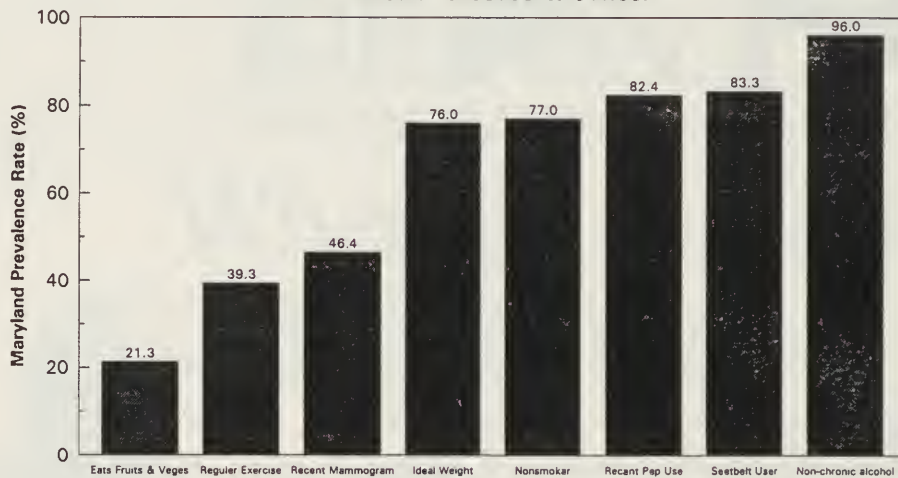
| <u>Risk Factor</u> | <u>Estimated Number of Deaths in MD Per Year*</u> |
|----------------------|---|
| Smoking | 7 700 |
| Diet/Exercise | 5 800 |
| Alcohol | 1 900 |
| Microbial Agents | 1 700 |
| Toxic agents | 1 200 |
| Firearms | 700 |
| Sexual Behavior | 600 |
| Motor Vehicles | 500 |
| Illicit Use of Drugs | 400 |

*Adapted from McGinnis JM, Foege WH. JAMA, 1993

The Physician's Role

The advice of the physician is persuasive in motivating a patient by promoting or reinforcing healthy behaviors, supporting the

Figure 1. Healthy Behaviors Relevant to Cardiovascular Disease & Cancer



Eats Fruits & Veggies: Reports Eating 5 or more fruits and vegetables per day, 1990-91.
 Regular Exercise: Reports doing some form of exercise regularly, 1987-91.
 Recent Mammogram: Mammogram reported within the past year among women 50 and older, 1987-91.
 Ideal Weight: Reported weight with respect to height is at or below 120% of ideal weight defined as midrange of the 1959 Metropolitan Life tables, 1987-91.
 Nonsmoker: Former smoker or never smoker, 1987-91.
 Recent Pap Use: Pap smear reported within past 2 years, 1988-91.
 Seatbelt User: Reports use of seatbelt "always" or "nearly always", 1987-91.
 Non-chronic alcohol: Reports consuming less than 2 drinks per day in the past month, 1987-91.

patient to change risky behaviors, or influencing patients to use preventive services. In 1991, 70% of Maryland adults had seen a physician in the preceeding year, with an estimated 95% having made a visit in the preceding three years. The majority (77%) of adults also reported they had a "usual source of care".

physician, on average, will see one or more patients a day having behaviors which impair health. In a day when 30 adults are seen, 17 do not exercise regularly or eat enough fruits and vegetables; 7 will be overweight; and 7 will be smokers. Some patients will have more than one unhealthy behavior. (Table 2)

Healthy/Unhealthy Behaviors

Most Maryland adults were abstainers or moderate imbibers of alcohol, used their seatbelts, received recent screening for breast and cervical cancer, maintained ideal body weight for height or were nonsmokers, though many had smoked in the past. Fewer than half of the adults engage in any form of regular exercise or eat 5 or more fruits and vegetables a day. (Figure 1)

Even for unhealthy behaviors which are relatively infrequent (such as being a chronic drinker, 3% of the adults), the primary care

Table 2

| Number of adult patients in a typical day at the office* | "Unhealthy" Behaviors |
|--|--|
| 24 | eat fewer than 5 fruits & vegetables a day |
| 17 | did not exercise regularly in past month |
| 7 | are overweight |
| 7 | are smokers |
| 4 | do not always use their seatbelt |
| 3 | have had 5 alcohol drinks in one sitting in past month |
| 1 | has 2 or more alcoholic drinks every day |

*For a "typical day at the office", 30 adult patients and the 1991 BRFS results were used for the calculations

Physicians have a role in giving cessation advice and referrals for behavior change. Brief smoking cessation advice has been shown to be effective in increasing the smoking quit rate by 50%(5). Persons who obtain dietetic counselling, especially by a nurse, registered dietician or nutritionist, are likely to lose weight and make positive changes to their diet(5).

Preventive Measures

Almost 90% of Maryland adults have some type of health insurance. Generally, the highest income group is twice as likely to have insurance than persons with less income(4). Despite the real financial barriers to obtaining preventive care for a person who does not feel sick, the public health goals for the U.S. and Maryland recommend that certain screening tests be performed more frequently. Currently, the MD DHMH and the CDC are sponsoring low cost mammography and Pap smears for low income and under-insured women to address financial barriers.

Table 3 displays how many adults seen during one day in a physician's office have not utilized certain preventive measures according to the BRFS. The most common test done is the Pap test and the least frequently done test is cholesterol measurement. Twenty percent of women over 40 have never had a mammogram. The reason given most often by women who

Table 3

Number of adult patients in a typical day at the office*

Lack of Preventive Measures Done

| | |
|----|---|
| 3 | women over 40 have not had a mammogram |
| 1 | woman has never had a Pap smear |
| 3 | have not had their blood pressure checked in the past year |
| 10 | have never had a blood cholesterol test |
| 3 | are elderly patients (65+) who have not had a flu shot in the past year** |

*For a "typical day at the office", 30 adult patients and the 1991 BRFS results were used for the calculations

**1987 BRFS was used

haven't had a mammogram is that a physician did not recommend they get one.

Total serum cholesterol screening is recommended by the U.S. Preventive Services Task Force(5) as a preventive measure used only within clinical practice and is not viewed as a screening test. Pap and mammography meet the criteria of sensitivity, specificity, and low cost for a public health screening test (6); flu shots are recommended prophylaxis (5).

The Physician as Support for Preventive Health Behaviors

Another physician role is to remind the patient to comply with recent guidelines for tests and to counsel toward behavior change. Physicians who use reminder systems increase their patients' use of preventive measures, in part because the physician and the patient have clearer expectations or goals. (Table 4)

Table 4

Number of adult patients in a typical day at the office*

Need Support for Preventive Behaviors

| | |
|----|---|
| 2 | are women over 50 who haven't had a mammogram in the past 2 years |
| 2 | are women who haven't had a Pap Smear in the past 2 years |
| 10 | are adults who have not had their cholesterol checked in the past 5 years |
| 11 | have tried to lose weight during the past year |
| 15 | have tried to quit smoking in the past year |
| 4 | wear their seatbelts only sometimes, rarely or never |
| 4 | sometimes drink and drive |
| 7 | are aware of their hypertension and are untreated pharmacologically |
| 7 | are aware of their hypertension and have not changed their diet |

*For a "typical day at the office", 30 adult patients and the 1991 BRFS results were used for the calculations

The U.S. Preventive Services Task Force(5) and the MD DHMH(8) have both put forth goals for the Year 2000. Disease outcomes, services, protection measures, and risk reduction goals are each addressed. (Table 5)

Table 5

| Year 2000 Goal for MD & US | MD 1990 |
|---|---------------|
| Disease: | |
| Reduce breast cancer mortality to 20.6/100,000* | 23.7/100,000 |
| Slow the rise of lung cancer mortality to not exceed 42.0/100,000* | 47.8/100,000 |
| Reduce heart disease** mortality to 126/100,000* | 160.3/100,000 |
| Reduce cerebrovascular disease** mortality to 20.0/100,000 | 27.2/100,000 |
| | MD 1991 |
| Risk reduction: | |
| Reduce prevalence of no physical activity to 15% | 28% |
| Reduce overweight prevalence to 20% | 22% |
| Reduce cigarette smoking prevalence to 15% | 23% |
| Services and Protection: | |
| Increase prevalence of women who are 50 or older who had a mammogram in past 2 years to 60% | 73% |
| Increase prevalence of women 18 and older who had a Pap smear within past 2 years to 85% | 84% |

*Age-adjusted to 1940 US population

**Modified for the National Center for Health Statistics definition of heart disease rather than the narrower category of ischemic heart disease

Physicians are essential in achieving these goals by encouraging their patients to increase the frequency of healthy behavior, to use preventive services, and to reduce risky behaviors.

Smoking cessation materials, are available from NCI by calling (800) 422-6237, and from CDC, (800) 232-1311. The "Put Prevention Into Practice" Program will provide materials about other prevention activities upon request; call (202) 205-8660

- MD DHMH. MD Vital Statistics Annual Report 1990. DHMH Division of Health Statistics: Baltimore, 1993.
- MD BRFS conducted under a cooperative agreement (U58/CCU, #303445) with the CDC since 1987. Alyse Weinstein is the survey coordinator.
- McGinnis JM and Foege WH. Actual Causes of Death in the U.S. JAMA, Vol 270 (18), November 10, 1993.
- MD DHMH. Healthy Lifestyles: Maryland Behavioral Risk Factor Surveillance System, 1987-1991. Preliminary Report. MD DHMH: Baltimore, 1993.
- U.S. Preventive Task Force. Guide to Clinical Preventive Services. U.S. Government Printing Office: Washington, DC, 1989.
- Mausner JS and Bahn AK. Epidemiology: An Introductory Text. W.B. Saunders Company: Philadelphia, 1974.
- U.S. PHHS. Healthy People 2000: National Health Promotion and Disease Prevention Objectives. U.S. Government Printing Office: Washington, DC, 1991.
- MD DHMH. Healthy Maryland 2000. Vol 1, May 1993.
- CDC Physicians and Other Health Care Professional Counselling of Smokers to Quit - US 1991. Vol 42 (44), November 12, 1993.

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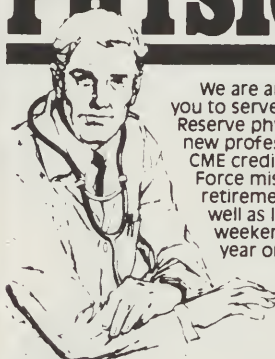
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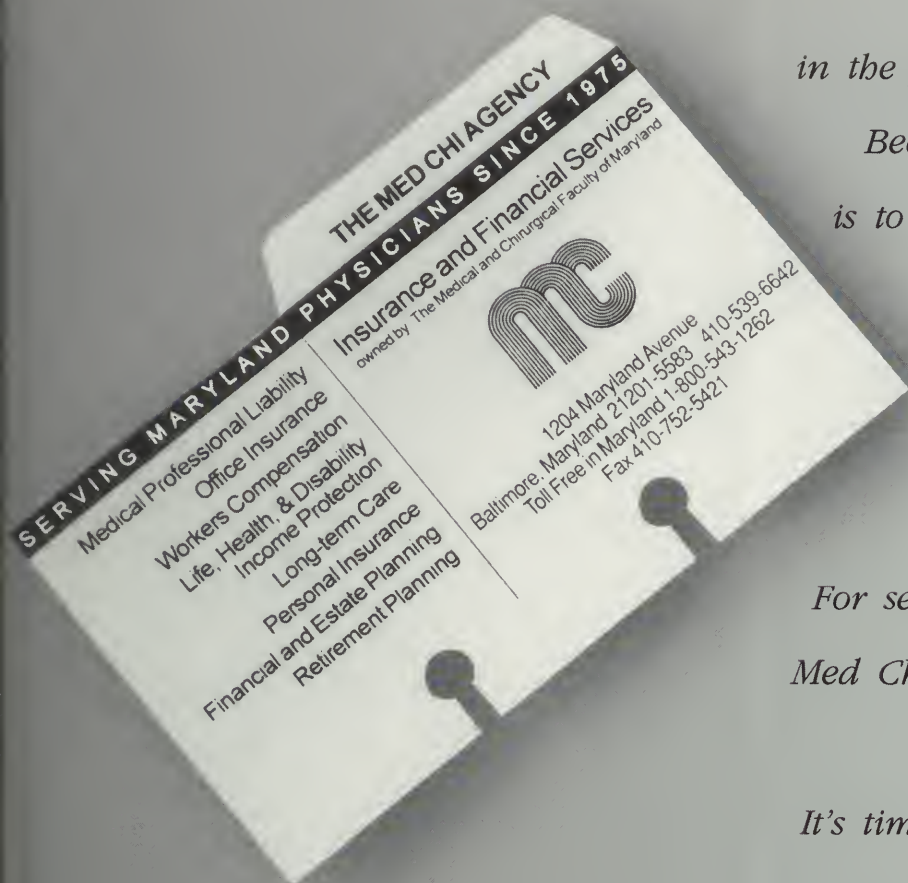
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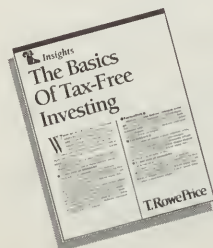
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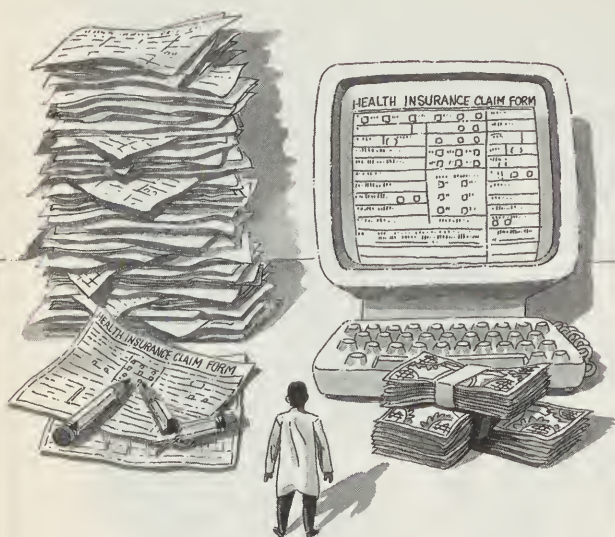
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8300 Boone Boulevard
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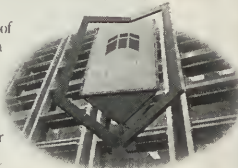
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Chief Executive Officer's Newsletter

February 1994

Preliminary Program — 1994 Med Chi Annual Meeting

The preliminary program for the 196th Annual Meeting of the Medical and Chirurgical Faculty of Maryland, "Medicine Under Health System Reform — Impact on Patients and Physicians," immediately follows this issue of the *Chief Executive Officer's Newsletter*. All information on business meetings, continuing medical education (CME) sessions, social events, and hotel accommodations is included. If you have any general questions regarding the preliminary program, please call the Communications Department at 410-539-0872 or 1-800-492-1056.

President's Southern Regional Conference

The President's Southern Regional Conference will be held at the Holiday Inn Conference Center, Solomons, Maryland, on Thursday, April 7, 1994, from 4:30 p.m. to 8:30 p.m. Members will receive an update on current Med Chi events, followed by a CME presentation, "Standards for Identifying and Treating Common Infectious Diseases," presented by Jonathan Cohn, M.D., assistant professor, Division of Infectious Diseases, Department of Medicine, University of Maryland. Dinner will be provided. There is no charge for this conference, but reservations are required. To register, call the Continuing Medical Education Department at 410-539-0872 or 1-800-492-1056.

Med Chi Study Group for Alternative Medicine

"Psychoneuroimmunology (Biopsychology): the Basis of the Mind-Body Interface" is the title of the program that will be presented by Leonard A. Wisneski, M.D., clinical professor of medicine at George Washington University Medical School and director of medical education at Holy Cross Hospital, Silver Spring, at the third meeting of the Med Chi Study Group for Alternative Medicine. The meeting will be held on Wednesday, May 4, 1994, at 7:30 p.m. in the Med Chi Faculty Building. Med Chi members, nonmember physicians, and other health care professionals are invited to attend. Please call Steve Jones at Med Chi at 410-539-0872 or 1-800-492-1056, ext. 343, or Hiroshi Nakazawa, M.D., at 410-644-1502, if you wish to attend or would like to receive additional information regarding the study group.

Med Chi Information Hotline

The new Med Chi Information Hotline is on-line and ready for use. The hotline will be very useful in providing members with up-to-date information on state and federal legislative issues, various topics of importance, and information on Med Chi events. The hotline will be updated as new information is available on each topic.

In order to access the Information Hotline, you must dial: 1-800-209-9126.

A message of introduction will be followed by a menu of topic options. For information on

- ♦ Clinton's health system reform plan, press 1,
- ♦ key state legislative issues, press 2,
- ♦ status of House Bill 1359, press 3,
- ♦ patient access/any willing provider legislation, press 4,
- ♦ wrongful death legislation, press 5,
- ♦ managed care issues, press 7, and
- ♦ upcoming events and important dates, press 8.

After choosing a topic and listening to the information on that topic, you may access another topic by following these steps:

(You can access another topic at anytime during the recording.)

- ♦ Press *, pause momentarily, press * again. (Pressing * * too quickly will result in the message: "star, star, I do not recognize this command, please try again.")
- ♦ After correctly pressing * pausing, and pressing * again, you will hear the message: "Please enter the mailbox number..."
- ♦ Press the corresponding mailbox number for the message you wish to hear next.

Mailbox numbers:

- 601 - Clinton's health system reform plan
- 602 - key state legislative issues
- 603 - status of House Bill 1359
- 604 - patient access/any willing provider legislation
- 605 - wrongful death legislation
- 607 - managed care issues
- 608 - upcoming events and important dates

(Please note, even though the mailbox numbers correspond to the original menu numbers, you must use the full mailbox number, not simply 1 through 8, to access additional topics.)

If you have any suggestions for, or questions about, the Med Chi Information Hotline, please call Taras Lukianczuk, director of Human Resources at 410-539-0872 or 1-800-492-1056, ext. 324.

*AMA Membership
Award Presented to
Med Chi*

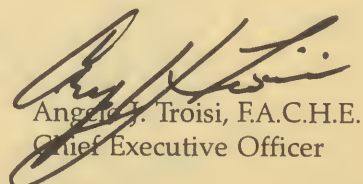
Med Chi was recently honored with an award for increasing AMA dues-paying membership for 1993, the third consecutive year our state surpassed its previous year's AMA membership. Med Chi President Joseph Snyder, M.D., accepted the plaque from AMA Trustee, Dr. Lonnie Bristow, February 12, 1994, on behalf of all Med Chi members.

*Physician
Rehabilitation
Program "Straight
Talk" Episode
Available on Tape*

"Straight Talk," a half-hour show aired on channel 45 at 10:30 a.m. every Friday, featured the Med Chi Physician Rehabilitation Program on January 28, 1994. The program is now being rebroadcast on local college cable stations. The show reviewed the current program, featured recovery stories, and highlighted the Physician Rehabilitation Committee's work on the issue of sexual misconduct in the practitioner's office. If you would like to receive a copy of the tape, please contact the Physician Rehabilitation Program at 410-962-5580 or 1-800-992-7010.

*AMA Conference on
Resource-Based
Relative Values Scale
(RBRVS)*

The AMA is sponsoring a national conference May 5 - 6, 1994, "Physician Payment and the RBRVS: Choice, Fee-for-Service, and Health System Reform." The conference will be held at the Hyatt Regency, Chicago, Illinois. Reservations must be received by April 14 and can be made by calling 1-800-621-8335.


Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

196th Annual Meeting of the Medical and Chirurgical Faculty of Maryland



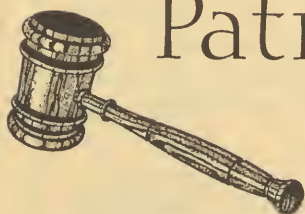
at the

Ramada Inn and Convention Center
Hagerstown, Maryland
Thursday-Saturday, May 12-14, 1994

Preliminary Agenda



Medicine
Under Health
System Reform —
Impact on
Patients and
Physicians



For room reservations at the Ramada,
please call 301-733-5100 or
1-800-272-6232 and

*Tax and
incidentals not
included.



The Ramada Inn and Convention Center is located at 901 Dual Highway (Route 40 West) in Hagerstown, Maryland.

From Baltimore
and points east:

Take I-70 West toward Hagerstown to exit 32B (Route 40 West). After taking exit 32B, proceed approximately 2.5 miles on Route 40. The Ramada Inn and Convention Center will be on your left.

From Montgomery
County, Washington and
points south:

Take 270 North to Frederick. Exit onto I-70 West and take I-70 West to exit 32B (Route 40 West). After taking exit 32B, proceed approximately 2.5 miles on Route 40. The Ramada Inn and Convention Center will be on your left.

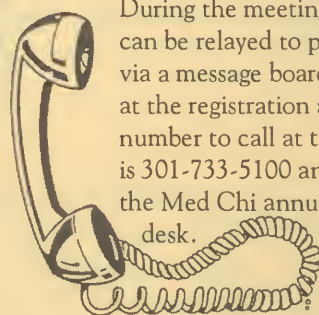
From Western Maryland
and points west:

Take I-70 East toward Hagerstown to exit 32B (Route 40 West). After taking exit 32B, proceed approximately 2.5

miles on
Route 40.
The
Ramada
Inn and
Convention
Center will
be on your
left.

Telephone Messages

During the meeting, messages can be relayed to participants via a message board located at the registration area. The number to call at the Ramada is 301-733-5100 and ask for the Med Chi annual meeting desk.



Miscellaneous

Questions about continuing medical education sessions? Call Joan Mannion at 1-800-492-1056 or 410-539-0872.

General questions about the annual meeting should be directed to Ruth Seaby or Vivian Smith at 1-800-492-1056 or 410-539-0872.



Program design: Virginia Carter

Please note-this is a preliminary program. More meetings, events and continuing medical education activities may be added to the final program which will be distributed at the meeting.

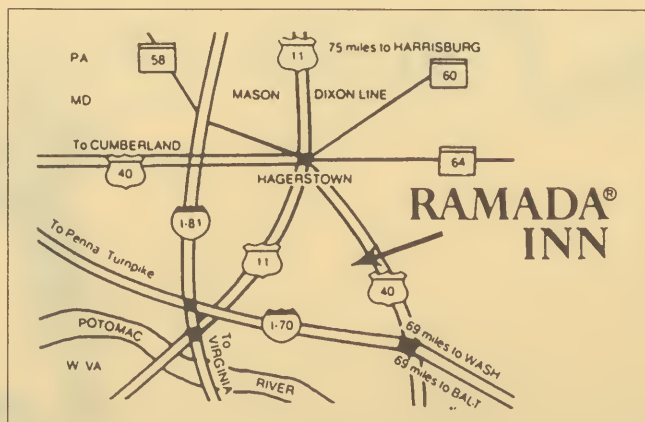
Continuing Medical Education Credits

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for up to 24.5 hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Physicians attending this year's meeting can earn up to a maximum of 14 CME credits.

Thanks

The Medical and Chirurgical Faculty of Maryland wishes to thank Abbott Laboratories, The Med Chi Agency, Pfizer, Inc., SmithKline Beecham Pharmaceutical and The Upjohn Company for helping to support the annual meeting's continuing medical education program.



Support Our Exhibitors

Exhibits are an integral part of the Med Chi Annual Meeting and are a valuable adjunct to the scientific program.

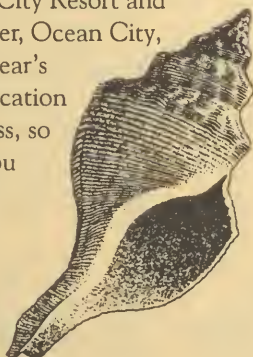
During this year's annual meeting, Med Chi has allocated several special time periods for physicians to meet one-on-one with exhibitors. By visiting exhibits, you will help ensure that Med Chi continues to receive valuable income that allows us to offer you annual and semiannual meetings.

FINANCIAL ADVICE Med Chi urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.

DRUG MANUFACTURERS

1994 Semiannual Meeting

Plan now to attend the Med Chi 1994 Semiannual Meeting, Friday, September 9 to Sunday, September 11, 1994, at the Sheraton Ocean City Resort and Conference Center, Ocean City, Maryland. Last year's meeting at this location was a great success, so we hope to see you there!



INSURANCE

Special Events

Meal Events

WOMEN IN MEDICINE LUNCHEON

\$10.00

Thursday, May 12, 1994

1:00 pm - 2:00 pm

Committee on Women in Medicine

This luncheon is open to all women physicians and their spouses.

WELCOME RECEPTION SPONSORED BY THE RAMADA INN IN THE BALLROOM

Thursday, May 12, 1994

6:30 pm - 7:30 pm

Relax with your colleagues and enjoy drinks and hors d'oeuvres compliments of the Ramada. Exhibits will be open during this event.

PRAYER BREAKFAST \$6.00

Friday, May 13, 1994, 8:00 am - 9:30 am

Committee on Medicine and Religion

Enjoy a breakfast buffet with like-minded caring physicians while hearing M. Roy Schwarz, M.D. speak on the topic "The Current Imperative for an Ethical Renaissance in Medicine." Problems of ethical misconduct and their impact on physician/patient relationships will be explored. The credibility of physician leadership in biomedical ethical issues will also be discussed.

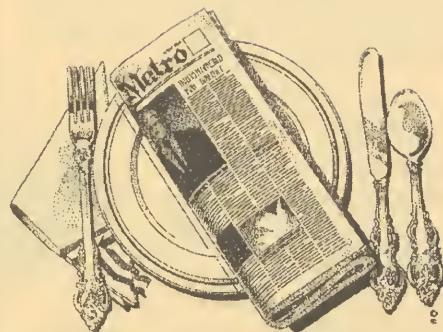
Dr. Schwarz is senior vice president for medical education and science with the AMA. One CME credit will be awarded to participants.

RECEPTION WITH THE PERCUSSION ENSEMBLE OF THE MARYLAND SYMPHONY ORCHESTRA NO CHARGE

Friday, May 13, 1994

6:30 pm - 7:30 pm

Hosted by the Washington County Medical Society.



SUCCESSFUL INVESTMENT STRATEGIES FOR PHYSICIANS NO CHARGE

Saturday, May 14, 1994

8:00 am - 9:30 am

This special breakfast meeting is sponsored by *Physician's Practice Digest*. Pre-registration is required for this breakfast meeting.

Marianne Billek-Kuta, investment executive for Ferris, Baker, Watts, Inc. will update physicians on current trends in investment strategies, including the risks and benefits associated with investments in stocks, mutual funds, real estate and art.

No CME credit will be given for this lecture.

PRESIDENTIAL BANQUET \$50.00

honoring Donald H. Dembo, M.D.

Saturday, May 14, 1994

6:30 pm - 11:00 pm

Featuring: Gene Donati Presentations

As orchestra leaders go, Gene Donati is the scientist - combining personality, reputation, hard work and requiring complete dedication from his musicians. Mr. Donati's orchestra performs frequently in the Washington competitive society-music market, including performances at the White House.



Bus Trips

Saturday, May 14, 1994
9:00 am -3:00 pm

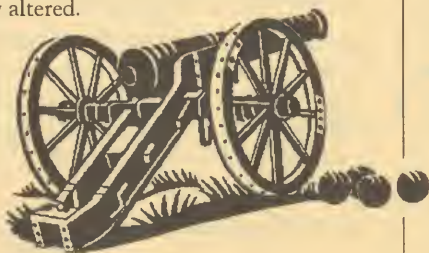
A minimum of 20 participants is needed for these events; if a trip is canceled due to insufficient registration, registrants' money will be refunded. Deadline for registration is April 29, 1994.

CHOICE A - HISTORICAL DAY \$25.00

10:00 am - 12:00 Antietam Battlefield
12:30 pm - 2:00 pm Lunch at the Bavarian Inn

Antietam Battlefield
Sharpsburg, Maryland

The Battle of Antietam (or Sharpsburg) on September 17, 1862, climaxed the first of Confederate General Robert E. Lee's two attempts to carry the war into the North. When the fighting ended that day, "The Bloodiest Day of the Civil War," the course of the American Civil War had been greatly altered.



CHOICE B - A DAY AT THE OUTLETS \$9.00

10:00 am -3:00 pm - Shopping at the Martinsburg Outlets

Blue Ridge Outlet Center
Martinsburg, West Virginia

This outlet center, "the authentic manufacturers outlet," is a renovated historic woolen mill dating to the turn of the century. Leading manufacturers of everything from clothing to housewares offer savings of up to 70%. Retailers include:

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| Boston Trader | Factory Linens |
| Brassworks | Famous Brands Housewares |
| Carter's Childrenswear | Five Sisters Gifts |
| Champion Athletic Apparel | Flapdoodles |
| Corning/Revere | Fuller Brush |
| Country Road Australia | Georgetown Leather Design |
| CW Company Store | Gold-N-Silver |



Fine Dining

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The Bavarian Inn's award-winning restaurant is located in the Greystone Mansion, located on grassy lawns, overlooking the Potomac River. The dining rooms are bright and elegant, decorated with antiques, beautiful china and deer horn chandeliers. The international cuisine offers a wide variety of German and American specialties.

Office Managers' Afternoon

Friday, May 13, 1994
2:30 pm - 6:00 pm

2:30 pm - 5:00 pm

This special time has been set aside for physician office managers to get a look at the latest in medical office equipment, billing services, automated office management systems, and more. Special drawings will be held in the exhibit hall during this time — win prizes donated by exhibitors and Hagerstown merchants.

5:00 pm - 6:00 pm

PERSONNEL HIRING, RETENTION AND FIRING

Janet Cline Patrick
President, Medical Personnel
Services, Inc.



Ms. Patrick will discuss personnel management issues which concern all involved in human resources.

6:30 pm - 7:30 pm

You are welcome to attend a reception with music by the Percussion Ensemble of the Maryland Symphony Orchestra and hosted by the Washington County Medical Society.

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| Ribbon Outlet |
| Robert Scott & David Brooks |
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| Socks Galore |
| Stephen Street Emporium |

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| Totes/Sunglass World |
| Toy Liquidators |
| Trader Kids |
| Van Heusen |
| Wallet Works by Amity |
| West Virginia Fine Glass |
| Woolrich Outlet |

Lunch on your own at one of three eateries—
The American Deli, Judy's Restaurant or Clock Cafe.

Scientific Sessions

Thursday, May 12, 1994

8:30 am - 5:00 pm

REGISTRATION/EXHIBITS OPEN

9:00 am - 4:00 pm

AUXILIARY 45TH ANNUAL MEETING

9:00 am - 11:00 am

STEP-BY-STEP: DOCUMENTING YOUR CME PROGRAM

Committee on Continuing Medical Education Review

Speakers:

William L. Thomas, M.D.

Chair, Committee on Continuing Medical Education Review

Joan Mannion, M.S., M.Ed.

Director, Department of Continuing Medical Education, Med Chi

Susan Dilles, B.S.

Education Unit, Upjohn Company

Objectives: Participating physicians will understand

- ☞ what documentation is necessary to demonstrate compliance with the seven "Essentials" and
- ☞ how to document compliance with the "Standards for Commercial Support of the CME"

Target Audience: All physicians involved in planning CME activities and supporting organizational staff

CME Credits: 2.0

Essentials
of Accreditation

9:00 am - 11:00 am

TRIALS AND DELIBERATIONS IN MEDICINE

Committee on Scientific Activity and Medical Mutual Liability Insurance Society of Maryland (Med Mutual)

(Medical Mutual members who attend this session are eligible for a 5% premium discount on their 1995 medical professional liability renewal policy. A \$40 program fee is required for this discount.)

Speakers:

Daniel E. Kohn, M.D.

Associate Director, Harbor Hospital Center

Beth A. Petree, J.D.

Claims Moderator, Medical Mutual

Marilyn Gilbert

Claims Supervisor, Medical Mutual

Objectives: Participating physicians will

- ☞ be able to identify current patient care issues,
- ☞ have an increased knowledge of medical diagnostic and treatment options,
- ☞ be able to describe the legal process, from service of suit through trial, and
- ☞ be able to discuss the application of risk management recommendations.

Target audience: All physicians

CME Credits: 2.0



11:00 am - 11:30 am

BREAK - VISIT THE EXHIBITS

11:30 am - 1:00 pm

AIDS AWARENESS AND DETECTION: ADOLESCENTS, WOMEN AND YOUNG ADULTS

Committee on AIDS, Women in Medicine Committee and Immunizations and Infectious Diseases Subcommittee of the Committee on Public Health

Speakers:

Robert J. Ancona, M.D.

Chair, Immunizations and Infectious Diseases Subcommittee of the Committee on Public Health; Chief, Department of Pediatrics, Union Memorial Hospital

Stanley I. Blum, M.D.

Chief, Division of Otolaryngology, North Arundel Hospital

Jean Anderson, M.D.

Assistant Professor, Department of Obstetrics and Gynecology, Johns Hopkins University School of Medicine

Margaret T. Snow, M.D.

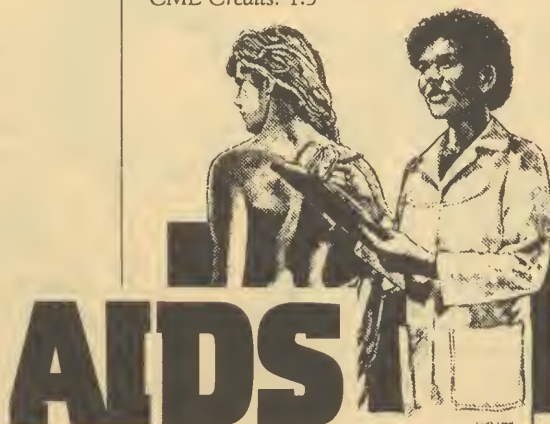
Chair, Committee on AIDS

Objectives: Participating physicians will be ☞ better able to recognize the manifestations of undiagnosed HIV, particularly in women and young people

- ☞ more knowledgeable about the importance of specialist involvement in the treatment of HIV positive patients and patients with AIDS,
- ☞ aware of the most recent advances in evaluation and treatment of HIV-positive patients and patients with AIDS.

Target Audience: All physicians

CME Credits: 1.5



Medicine Under Health System Reform—Impact on Patients and Physicians

Jesse C. Coggins Memorial Lecture

11:30 am - 1:00 pm

HEALTH CARE DECISIONS ACT: NEW RIGHTS AND RESPONSIBILITIES

Long-Term Care and
Geriatrics
Committee



Speaker:

Jack Schwartz, Esq.

Office of the Attorney General

Overview of the Health Care Decisions
Act as it Pertains to Physicians' Rights and
Responsibilities in Patient Care

Panel:

Jack Schwartz, Esq.

Timothy Keay, M.D., M.A.

Chair, Patient Care Advisory Panel, Deaton
Specialty Hospital, University of Maryland
School of Medicine

Henry Silverman, M.D.

Chair, Committee on Professional Ethics,
Director MICU, University of Maryland
Medical System, Inc.

Objectives: Participating physicians will

- ☞ be aware of the rights and responsibilities of physicians in patient care under the Health Care Decisions Act and
- ☞ be aware of criteria and procedures for implementing decision-making in various settings, such as intensive care units, nursing homes and offices.

Target Audience: Family practitioners, psychiatrists and internists

CME Credits: 1.5

1:00 pm - 2:00 pm

LUNCH ON YOUR OWN

1:00 pm - 2:00 pm

WOMEN IN MEDICINE LUNCHEON

Registration and a \$10 fee are required to attend this luncheon. See page 3 for details.

2:00 pm - 5:00 pm

(Break 3:30 pm - 4:00 pm)

MEDICINE IN TRANSITION: STRATEGIES FOR CHANGE

(Panel Presentation)

Committee on Managed Care and Third-Party
Liaison

Moderator:

Benjamin Avrunin, M.D.

Chair, Committee on Managed Care and
Third-Party Liaison

Objectives: Participating physicians will

- ☞ review the definitions and economics of managed care,
- ☞ take a close look at President Clinton's health system reform plan, federal legislation and the implications for physicians,
- ☞ acquire a deeper understanding of the managed care marketplace with an emphasis on local and regional trends and issues,
- ☞ confront, in a rational and realistic way, the dilemmas physicians may face — issues of autonomy, control, competition, loss of revenue, ethical concerns, administrative hassles, and legal issues, and
- ☞ gain insight into how physicians can and should - control clinical decision making in managed care.

Target Audience: All physicians

CME Credits: 2.5

3:30 pm - 4:00 pm

BREAK - VISIT THE EXHIBITS

5:00 pm - 6:00 pm

OFFICE AND CLINIC SECURITY RISKS

Medical Mutual Liability Insurance Society of
Maryland

Speaker:

John Piper

President, Sciencetech, Inc.

Objectives: Participating physicians will

- ☞ be aware of security risks in offices, clinics, hospitals and nursing homes and
- ☞ know steps that can be taken to minimize these risks.

Target Audience: All physicians and office personnel

CME Credit: None



5:00 pm - 6:00 pm

THE IMPACT OF NEW TECHNOLOGY AND COST CONTROL AND TREATMENT OPTIONS FOR BPH (BENIGN PROSTATIC HYPERPLASIA)

Committee on Scientific Activity and the
Division of Neurology, University of
Maryland

Speaker:

Michael J. Nasland, M.D., M.B.A.

Assistant Professor of Urology, The
University of Maryland School of Medicine;
Director, Maryland Prostate Center

Objectives: Participating physicians will be

- ☞ aware of new medical treatment options for benign prostatic hyperplasia (BPH)
- ☞ aware of developing technologies that will probably play a role in BPH treatment, such as laser, microwave and stents and
- ☞ able to discuss an economic model that can be used to quantitatively compare the long-term cost of treating BPH with surgery vs. medications.

Target Audience: Family practitioners, internists, surgeons and other physicians who treat elderly men

CME Credit: 1.0

5:00 pm - 6:00 pm

WHAT PHYSICIANS NEED TO KNOW ABOUT TUBERCULOSIS TODAY

*Immunizations and Infectious Diseases
Subcommittee of the Committee on Public Health*

Speakers:

William Randall, M.D.
Maryland State Pulmonologist

Diane Matuszak, M.D.
Chair, Maryland Committee for the Elimination of Tuberculosis

Objectives: Participating physicians will be able to

- describe the changing epidemiology of tuberculosis in the US and Maryland,
- describe new treatment guidelines for tuberculosis including recommendations for an initial four-day drug regimen and directly observed therapy (DOT) and
- describe OSHA requirements for control of tuberculosis

Target Audience: Primary care physicians

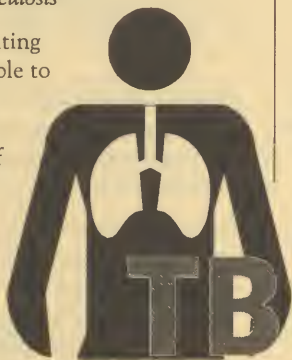
CME Credit: 1.0

6:30 pm - 7:30 pm

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Exhibits open

See "Special Events" on page 3 for details.



Scientific Sessions

Friday, May 13, 1994

7:30 am - 5:00 pm

REGISTRATION/EXHIBITS OPEN

8:00 am - 9:30 am

PRAYER BREAKFAST

Registration and a \$6.00 fee are required to attend this breakfast. See page 3 for details.

THE CURRENT IMPERATIVE FOR AN ETHICAL RENAISSANCE IN MEDICINE

Committee on Medicine and Religion

Speaker:

M. Roy Schwarz, M.D.

Senior Vice President for Medical Education and Science, American Medical Association

Objectives: Participating physicians will be more aware of

- the problems of ethical misconduct within the medical profession, and the impact these are having on the physician/patient relationship,
- the question of the credibility of physicians and physician leadership on biomedical ethical issues and
- possible solutions to these problems.

Target Audience: All physicians

CME Credit: 1.0

8:00 am - 10:00 am

PATIENT EDUCATION AND THE MEDIA: WHEN "60 MINUTES" COMES KNOCKING

*Committee on Scientific Activity and
Committee on Young Physicians*

Speaker:

Patricia Clark

Director, AMA Media/Speech Training Services

Objective: Participating physicians will

- gain skills enabling them to communicate more effectively and authoritatively with patients, with the public in small and large groups, and on radio and television.

Target audience: All physicians

CME Credits: 2.0

8:30 am - 5:00 pm

AUXILIARY - 45TH ANNUAL MEETING

9:30 am - 11:30 am

COUNCIL MEETING

WELCOMING REMARKS:

The Honorable Roscoe Bartlett
US House of Representatives, Maryland 6th District

11:30 am - 1:00 pm

LUNCH ON YOUR OWN

1:00 pm - 2:00 pm

HEALTH SYSTEM REFORM IN MARYLAND

Speakers:

William Richardson, Ph.D.

*President, The Johns Hopkins University;
Chair, Health Care Access and Cost Commission*

Alex Azar, M.D.

Commissioner, Health Care Access and Cost Commission

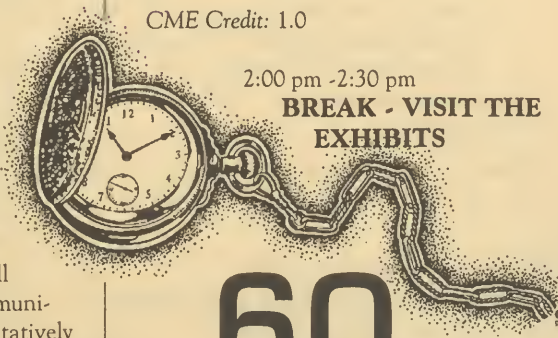
Objective:

- Participating physicians will be aware of the issues and problems regarding health system reform at the state level.

CME Credit: 1.0

2:00 pm - 2:30 pm

BREAK - VISIT THE EXHIBITS



60 MINUTES

Medicine Under Health System Reform—Impact on Patients and Physicians

2:30 pm - 5:00 pm

KEYNOTE ADDRESS:

Robert E. McAfee, M.D.

President-elect, American Medical Association

HOUSE OF DELEGATES MEETING

5:00 pm - 6:00 pm

GENERAL MEMBERSHIP MEETING



KEYNOTE SPEAKER

Robert E. McAfee, M.D.

President-elect, American Medical Association

Dr. McAfee, a surgeon practicing in South Portland, Maine, served as vice-

chairperson of the American Medical Association (AMA) Board of Trustees from June 1990 to 1992. He served as a member of the Executive Committee of the board from 1988 to 1992. He was appointed to serve as an AMA commissioner to the Joint Commission on Accreditation of Healthcare Organizations in January 1986 and continues in that capacity. He also served as president of the AMA Education and Research Foundation from 1986 to 1988, and as its secretary-treasurer from 1985 to 1986.

Born in Portland, Maine, Dr. McAfee received his M.D. degree from Tufts University School of Medicine in 1960. He completed his residency in general surgery at Maine Medical Center in 1965. He is a diplomate of the American Board of General Surgery, an attending surgeon at the Maine Medical Center and chief of vascular surgery at Mercy Hospital in Portland. He is also an associate professor at the University of Vermont.

Scientific Sessions

Saturday, May 14, 1994

8:00 am - 9:00 am

MEDICINE UNDER HEALTH SYSTEM REFORM: IMPACT ON ACADEMIC MEDICAL CENTERS

Committee on Scientific Activity and the University of Maryland Medical System

Speakers:

Stephen C. Schimpff, M.D.

Executive Vice President, University of Maryland Medical System; Professor of Medicine, Pharmacology, and Oncology, University of Maryland School of Medicine

Frank M. Calia, M.D.

Vice Dean, Professor of Medicine, University of Maryland School of Medicine

Objectives: Participating physicians will be able to discuss

- ❧ indicators of managed care market evolution and Maryland's position in this continuum,
- ❧ purchaser needs and expectations in a managed care environment,
- ❧ threats and opportunities facing academic medical centers in managed care environments and
- ❧ key elements for an effective integrated health services delivery system.

Target Audience: All physicians

CME Credit: 1.0

8:00 am - 9:00 am

EVALUATION AND TREATMENT OF DIZZINESS

Committee on Scientific Activity and the Dept. of Otolaryngology-Head and Neck Surgery, University of Maryland Medical System

Speaker:

Douglas E. Mattox, M.D.

Professor and Director, Otolaryngology-Head and Neck Surgery, University of Maryland Medical System

Objectives: Participating physicians will

- ❧ understand the pathophysiological mechanisms underlying the symptom of vertigo,
- ❧ be able to differentiate between central and peripheral vertigo,
- ❧ be able to diagnose syndromes of peripheral vertigo and
- ❧ be able to medically manage syndromes of peripheral vertigo.

Target Audience: Family practitioners

CME Credit: 1.0

8:00 am - 9:00 am

CURRENT TRENDS IN THE MANAGEMENT OF HEAD AND NECK CANCER AT WASHINGTON COUNTY HOSPITAL

Committee on Scientific Activity

Speaker:

Aryeh L. Herrera, M.D.

Diplomate, American Board of Plastic and Reconstructive Surgery

Objectives: Participating physicians will

- ❧ be aware of the incidence rates of head and neck cancer treated at Washington County Hospital and
- ❧ be able to discuss surgical, medical oncologic and radiotherapeutic methods currently used in the management of head and neck cancer in a county hospital setting.

Target Audience: Family practitioners, internists and surgeons

CME Credit: 1.0



6:30 pm - 7:30 pm

RECEPTION WITH THE PERCUSSION ENSEMBLE OF THE MARYLAND SYMPHONY ORCHESTRA

Hosted by the Washington County Medical Society.

See "Special Events" on page 3 for details.

Medicine Under Health System Reform — Impact on Patients and Physicians



8:00 am - 9:30 am

SUCCESSFUL INVESTMENT STRATEGIES FOR PHYSICIANS

Physician's Practice Digest

Pre-registration is required for this breakfast meeting. See page 3 for details.

Speaker:

Marianne Billek-Kuta

Investment Executive, Ferris, Baker, Watts, Inc.

Objective: Participating physicians will be
☞ updated on current trends in investment strategies, including the risks and benefits associated with investments in stocks, mutual funds, real estate and art.

Target Audience:
All physicians

CME Credit: None



9:00 am - 10:00 am

ADVANCES IN TECHNOLOGY AND DRUGS

Speaker:

Robert A. Ingram

President and Chief Operating Officer, Glaxo, Inc.

Objective: Participating physicians will

- ☞ become familiar with the impact of health system reform on research and development in the pharmaceutical industry

Target Audience: All physicians

CME Credit: None



9:00 am - 11:00 am

FAMILIES UNDER SIEGE — PHYSICIANS' ROLE IN COMBATING FAMILY VIOLENCE

Committee on Public Health and Public Relations Committee

Speakers:

Robert McAfee, M.D.

President-elect, American Medical Association

Martin P. Wasserman, M.D.

Chair, Committee on Public Health

Hiroshi Nakazawa, M.D.

Chair, Public Relations Committee

Joanne Tulonen

Executive Director, Maryland Alliance Against Family Violence

- Objectives:** Participating physicians will
- ☞ learn about the AMA's initiative against family violence,
 - ☞ learn about the Maryland Physicians' Campaign Against Family Violence
 - ☞ identify physician barriers to dealing with family violence,
 - ☞ identify appropriate physician responses to family violence,
 - ☞ identify victim barriers to seeking assistance,
 - ☞ identify victim responses to family violence and
 - ☞ learn about community response to family violence

Target Audience: All physicians

CME Credits: 2.0

9:00 am - 10:00 am

BREAKFAST MEETING—MARYLAND ASTHMA AND ALLERGY SOCIETY MEMBERS

10:00 am - 12:30 pm

(Break 11:00 am - 11:30 am)

BETA AGONIST AND INHALED CORTICOSTEROIDS: CURRENT ISSUES AND CONTROVERSIES

Maryland Asthma and Allergy Society

Speakers:

John H. Toogood, M.D., F.R.C.P.C.

Director, Allergy Clinic and Laboratory, Victoria Hospital, London, Ontario, Canada; Research Professor of Medicine, University of Western Ontario

Harold Stanley Nelson, M.D.

Co-Director, Allergy-Immunology Training Program, University of Colorado School of Medicine, Denver, Colorado; Professor of Medicine, University of Colorado School of Medicine

- Objectives:** Participating physicians will
- ☞ be able to describe the most current accepted practices in the use of beta agonist therapy and inhaled corticosteroids in the treatment of asthma,
 - ☞ be aware of the controversies surrounding the therapies and
 - ☞ be knowledgeable about treatments being developed.

Target Audience: Family practitioners, internists, allergists, pulmonologists, pediatricians and endocrinologists

CME Credits: 2.0

Medicine Under Health System Reform—
Impact on Patients and Physicians

Registration Form

PLEASE PRINT CLEARLY:

Name _____

Address _____

City, State _____ Zip _____

Telephone _____ Component Society _____

Spouse name (if attending the annual meeting) _____

CHECK ALL THAT APPLY

SCIENTIFIC SESSION REGISTRATION

| | Cost | # of Tickets | Total |
|---|-----------|--------------|-------|
| <input type="checkbox"/> Med Chi member | no charge | _____ | _____ |
| <input type="checkbox"/> Preregistered non member | \$100.00* | _____ | _____ |

*includes all CME presentations unless an additional charge is noted below

EVENT PRE-REGISTRATION

(See pages 3-4 for details on these events.)

| | | | |
|---|---------|-------|-------|
| <input type="checkbox"/> Women in Medicine Luncheon | \$10.00 | _____ | _____ |
|---|---------|-------|-------|

Thursday, May 12, 1994, 1:00 pm - 2:00 pm
(Open to all women physicians and their spouses)

| | | | |
|---|--------|-------|-------|
| <input type="checkbox"/> Prayer Breakfast (CME Credit: 1.0) | \$6.00 | _____ | _____ |
|---|--------|-------|-------|

Friday, May 13, 1994, 8:00 am - 9:30 am

| | | | |
|---|-----------|-------|-------|
| <input type="checkbox"/> Investment Strategies for Physicians | no charge | _____ | _____ |
|---|-----------|-------|-------|

Sponsored by *Physician's Practice Digest*
Saturday, May 14, 1994, 8:00 am - 9:30 am

Bus Trips

Saturday, May 14, 1994, 9:00 am - 3:00 pm
A minimum of 20 participants is needed for these events; if a trip is canceled due to insufficient registration, registrants' money will be refunded.

| | | | |
|--|---------|-------|-------|
| <input type="checkbox"/> Choice A - Historical Day | \$25.00 | _____ | _____ |
|--|---------|-------|-------|

| | | | |
|---|--------|-------|-------|
| <input type="checkbox"/> Choice B - Martinsburg Outlets | \$9.00 | _____ | _____ |
|---|--------|-------|-------|

| | | | |
|---|---------|-------|-------|
| <input type="checkbox"/> Presidential Banquet | \$50.00 | _____ | _____ |
|---|---------|-------|-------|

Saturday, May 14, 1994, 6:30 pm - 11:00 pm

Grand Total _____

Return this form with your check made payable to "Med Chi" to:

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For further information, call:

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Medicine Under Health
System Reform—Impact on
Patients and Physicians

Saturday,
May 14, 1994

9:00 am - 3:00 pm

BUS TRIPS - HISTORICAL DAY OR OUTLET SHOPPING

Registration and an additional fee are required for these trips. See page 4 for details.

10:00 am - 11:00 pm

CONSUMER RESPONSE TO HEALTH SYSTEM REFORM OPINION POLLS

Committee on Scientific Activity

Speaker:

Edward Goetas, III

President and CEO, Tarrance Group

Objectives: Participating physicians will
✎ understand how the public is responding to health system reform plans and
✎ discuss the most current findings of health system reform public opinion polls.

Target Audience: All physicians

CME Credit: 1.0

11:00 am - 11:30 am

BREAK - VISIT THE EXHIBITS

11:30 am - 12:30 pm

THE INSURANCE COMMISSION AND YOU

Dwight K. Bartlett, III

Insurance Commissioner for the State of Maryland

12:30 pm - 2:00 pm

LUNCH ON YOUR OWN

2:00 pm - 4:00 pm

HOUSE OF DELEGATES MEETING

(Council Meeting immediately follows House of Delegates meeting.)

6:30 pm - 11:00 pm

PRESIDENTIAL BANQUET HONORING DONALD H. DEMBO, M.D.

Featuring: Gene Donati Presentations

Registration and an additional fee of \$50 are required to attend this function. See page 3 for details.

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Negligent sanitation practices in Baltimore barber shops

With widespread recognition of the importance of universal precautions within the health care industry, one often assumes that these precautions are applied throughout other personal care industries. I have recently been to three separate barber shops that did not sterilize their razor blades between customers. I have learned to refuse a razor shave of my neck and sideburns and watch in horror as the barber uses a razor on a neighboring customer, wipes the blade on a cloth towel, and replaces it on a shelf to be reused. This has persisted despite several warnings from me as to the inherent danger.

I have contacted the Board of Barbers and obtained a copy of the relevant Code of Maryland. Regulation 09.16.02.04 of the Code of Maryland gives specific instructions for sanitation of a barber shop and requires that open "instruments used in direct contact with a client shall be washed in soap and water before being immersed in a disinfectant for the required period of time as specified." Appropriate disinfectants include diluted bleach for 10 minutes, 5% carbolic acid for 20 minutes, 4% formaldehyde for 20 minutes, or 7% alcohol for 20 minutes. After disinfection, all instruments must be stored in a cabinet containing an active "fumigant or electrical sanitizer."

I telephoned 12 barber shops at random, identified myself as a con-

cerned consumer, and asked them to describe their sanitation practices. Three of the 12 had abandoned using razors entirely for fear of the spread of communicable diseases. An additional three had adopted the use of disposable razors. Another four continued to reuse razors, but accurately described the regulations. One barber did not understand the question and did not appear familiar with the proper sanitary procedures. One other barber stated that he would certainly reuse a razor if it were not visibly contaminated with blood.

In this brief survey, I was able to identify at least one barber shop in addition to my own that is clearly in violation of state sanitary regulations. It is quite possible that this survey underestimates the extent of the problem. While there are no documented cases of human immunodeficiency virus (HIV) transmission in a barber shop, most barbers surveyed admitted that small nicks or cuts are quite common, and I fear that the poor sanitation practices exhibited by some barbers could be quite dangerous. I urge all physicians to be aware of this problem, and to report violators to the Board of Barbers at 501 St. Paul Place, Baltimore, MD 21202.

MICHAEL ARMSTRONG, JR., M.D.
Dr. Armstrong is president, Med Chi Resident Component ■

Fine-needle aspiration cytologic biopsies

I appreciate the comments of Dr. Herbert L. Muncie, Jr., published in the October 1993 issue. The comments were in reference to my letter to the editor in the same issue regarding needle aspiration cytologic breast biopsy.

I believe Dr. Muncie is correct when he states that there has not yet been a cost-effectiveness study done on fine-needle aspiration cytologic biopsies. I must point out, however, that fine-needle aspiration cytologic biopsies of the breast have been and are increasingly in use at virtually every major breast diagnostic center in the world because of the perceived efficiency, accuracy, and cost-effectiveness resulting from the diminished necessity for the two-stage management of patients who have fine-needle aspiration biopsy (FNAB) positive for cancer.¹⁻⁴ Much of the recent literature indicates sensitivity rates for carcinoma diagnosis ranging from 79% to 95%, while specificity rates for the positive diagnosis of cancer in centers with experienced cytopathologists approach 100% accuracy.

The presence of a positive cytologic diagnosis of cancer permits immediate planning for definitive surgical care without the need for additional pretherapeutic biopsies. Many surgeons still prefer to do an intraoperative core needle or excisional biopsy for further confirmation before definitive surgery is carried out.

Although I would not anticipate or recommend that every practicing

physician who recognizes a breast lump should do a fine-needle aspiration biopsy, I certainly would think that anyone sufficiently motivated to put a needle in a breast to evaluate a lesion would attempt to get the maximum information possible from that simple office procedure. If the diagnosis rendered by the cytopathologist is inconclusive or if an inadequate specimen has been submitted, then further specialty consultation is indicated. This may then lead to either repeat biopsies or excisional biopsy.

I believe the evidence is incontrovertible that throughout the world, tens of thousands of fine-needle aspiration biopsies have yielded a diagnosis of breast malignancy, and that false positives are usually less than 1%.

The CPT (current procedural terminology) code 19100 refers to needle biopsy of the breast. Medicare currently allows a charge of \$74.80. The service transaction code for the cytopathologic evaluation is 1788173, and this allows a charge of \$109.86. Combined, these charges total \$184.66. The CPT code for surgical breast biopsy is 19120, and Medicare currently allows a limited charge of \$305.44. A one-hour outpatient operating room charge with the patient operated on under local anesthesia is \$869.54 at my favorite hospital. For patients having a biopsy done under general anesthesia, the charge is \$1,174.98, and the maximum charge is \$1,639.84. Including the pathology charges for evaluating the tissue biopsy,

surgical excision for biopsy is anywhere from six to nine times more expensive than a needle biopsy. I would agree, however, with Dr. Muncie, that a well-designed cost-effectiveness study is overdue.

References

1. Hitchcock A, Hunt CM, Locker A, Koslowski J, Strudwick S, Elston CW, Blamey RW, Ellis IO. A one-year audit of the fine-needle aspiration cytology for the pre-operative diagnosis of breast disease. *Cytopathology* 1991; 2(4):167-76.
2. Gelabert HA, Hsiu JG, Mullen JT, Jaffe AH, D'Amato NA. Prospective evaluation of the role of fine-needle aspiration biopsy in the diagnosis and management of patients with palpable solid breast lesions. *Surg* 1990; 56(4):263-67.
3. Benedetto JC, Allora VG, Wyatt LL. Accuracy of fine-needle aspiration biopsy in diagnosis of palpable breast masses: two-year results of a university-affiliated community hospital. *J Am Osteopath Assoc* 1993; 93(5):585-88.
4. Naylor B. Fine-needle aspiration cytology of the breast—an overview. *Am J Surg Path* 1988; 12(Suppl. 1):54-61.

ROBERT E. MARTIN, M.D.
Baltimore, Maryland ■

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APRIL 17-23, 1994

Nursing home medicine in Maryland

George Taler, M.D.

*Dr. Taler is assistant professor,
Department of Family Medicine,
University of Maryland School of
Medicine, Baltimore, Maryland.*

ABSTRACT: *Long-term care continues to expand due to demographic, societal, and economic forces, and it is becoming a major factor in the reorganization of health care delivery. Nursing home medicine presents an unusual array of clinical and psychiatric problems, a different working environment, and a different set of administrative regulations. This care setting presents a challenge and an opportunity to the prepared physician.*

Recent changes in the long-term care sector have made the practice of medicine in this setting professionally rewarding and financially viable. The demographically driven demand for limited long-term care resources is augmented by federal policies that encourage earlier hospital discharge and by state reforms that provide incentives to nursing homes to raise their care capabilities. These policies have escalated the complexity of the medical care required by the average nursing home resident. Fortunately, Medicare reform has increased the remuneration for physician services provided in the nursing home so that the reimbursement is comparable with that provided in the acute care setting. There is growing support, both locally and nationally, for physicians to learn more about the nuances of nursing home medicine and about fulfilling the administrative role of medical director in these organizations.

The aging of the population

Changes in the age distribution of Maryland's population mirror those of the nation in many ways. According to the most recent US census, 517,000 people, or 10.8% of Maryland citizens, were 65 years of age or older in 1990. By 2010, it is estimated that there will be 757,000 in this age group—an increase of 46.4%. Most notable is the rapid rise in the population over 85 years of age—the “old old.” This segment is expected to more than double from approximately 50,000 to nearly 115,000 within this same time frame.¹

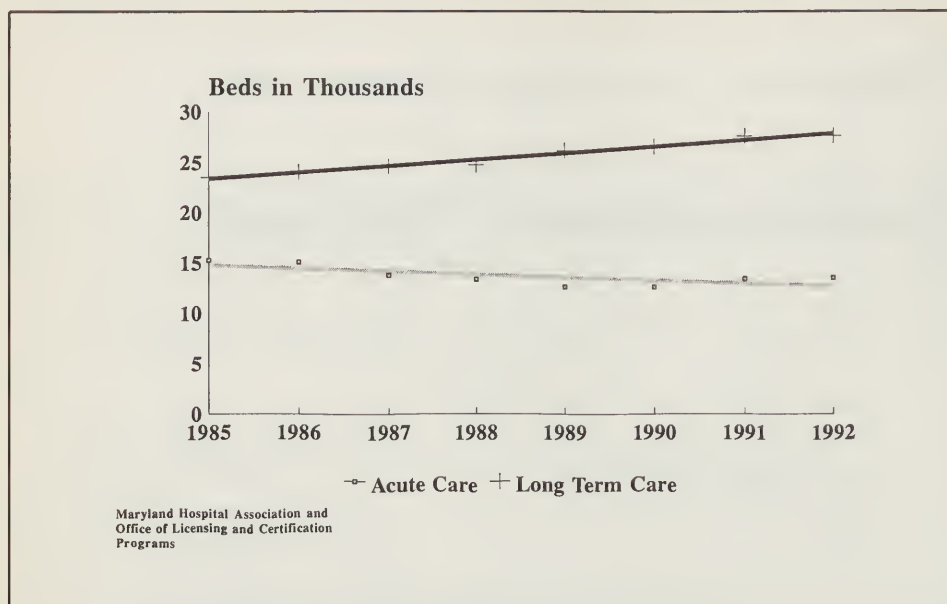


Figure 1. Acute and long-term care beds in Maryland

The growth of the nursing home sector

Although only 5% of the population 65 years of age or older reside in nursing homes, approximately 22% of the old old are institutionalized.² Another way of approaching this issue is from the perspective of an individual's lifetime risk of requiring nursing home care. Kemper and Murtaugh³ predict that for those individuals who turned 65 in 1990, 43% will spend some time in a nursing home during their remaining lifetime. The probability climbs with age at death: 17% of those who die between the ages of 65–74, 36% of those who die between ages 75–84, 60% of those who die between ages 85–94, and 71% of those who die after age 94 will spend some time in a nursing home. Clearly, the changes in the age distribution of our population will have a profound effect on nursing home use.

Demography is only one cause of demand for nursing home beds. The second major force has been the Medicare Prospective Payment System (PPS). (Although Maryland is exempt from PPS, the same incentives apply.) Since the implementation of PPS in 1983, the length of stay associated with hospitalization has dramatically declined. Patients have less time to recover, and other arrangements must be made for their convalescence and rehabilitation. Often, the best alternative is the nursing home. In fact, 6%–10% of discharged hospital patients go to nursing homes,⁴ accounting for approximately 80%⁵ of nursing home admissions.

This has led to an increase in the complexity of care required for patients admitted to long-term care facilities. Between 1982 and 1986, the percentage of patients that was admitted to Medicare-certified nursing homes and that required tube feedings increased from 21% to 29%; oxygen use increased from 6% to 14%; the percentage of patients admitted with urinary tract infections increased from 7% to 13%; and the percentage of patients admitted with diastolic

hypertension increased from 1% to 10%.⁶

Another impact of PPS is on the percentage of patients dying in hospitals vs nursing homes. As hospital deaths declined, the percentage of deaths occurring in nursing homes increased from 18.9% to 21.5%.⁷ Both Medicare and the Maryland Medical Assistance Program have responded to the need for greater capabilities in providing care by offering nursing homes financial incentives to accept more complex cases and providing disincentives to offer custodial care. Despite increases in reimbursement, costs have increased only half as much as in hospitals.⁸

The third major factor increasing the demand for long-term care beds is the Medicaid policy of deinstitutionalizing the chronically mentally ill. As these patients age, they become less a threat to themselves or others and less in need of the specialized services of a psychiatric facility. Those unable to reenter the community are transferred to nursing homes. The effect of this policy has been an influx to nursing homes of patients with severe mental retardation, schizophrenia with dementia, and other conditions that leave the patients highly dependent. The drugs, regimens, and management required for these patients increase the complexity of nursing home medicine.

Fourth, the growing market for long-term care insurance is likely to stimulate demand for nursing home beds in the near future. Realizing that nursing home care may cost from \$30,000 to \$60,000 per year has prompted older people to protect their assets. Medicaid loopholes will eventually be closed so that insurance will be the only mechanism to preserve one's estate. The financially based reluctance to access nursing home care will evaporate once the care is already paid for.

For all these reasons, there has been a steady pressure to increase the number of nursing home beds, but expansion has been curtailed through a restrictive certificate-of-need process exercised by state governments. Nationally, there are nearly 1.7 million beds in over 15,000 nursing homes⁹ with annual expenditures of more than \$53 billion.⁸ Care is paid for largely by the patients themselves (51.2%), followed by Medicaid (41.5%). Medicare pays only 2.1% of the total.¹⁰ The substantial obligations assumed by the state Medicaid programs have limited growth of the number of nursing home beds to approximately 2% per year over the past five years.¹¹ These same trends are found on a state level.

Despite these limits, growth in the number of nursing home beds has continued while the occupancy and number of acute care beds has waned. **Figure 1** compares the growth of long-term care beds with the decline in acute care beds since 1985 in Maryland. In 1989, there were twice as many long-term care beds as medical and surgical acute care beds. This change is magnified further by disparities in utilization. As of December 1992, the average occupancy in acute care beds in Maryland was 68.4%, down from 69.6% in 1991.¹² The average occupancy in long-term care beds has been a steady 94%–95%.⁹ There are approximately three patients in long-term care for every one patient in acute care.

Nursing home residents

Although the average nursing home patient is female (ratio to males is approximately 2.5:1) and in her 80s, nursing home residents are a highly diverse population. They can be categorized into two general groups.¹³ More than half of all nursing home admissions are short-stay patients who have come for convalescence and rehabilitation before returning home (approximately 30%) or for terminal care (approximately 40%). The rest either return to the hospital for continued care (approximately 25%) or are transferred to other facilities.⁵

The second major group comprising approximately 40% of admissions includes those whose length of stay extends beyond six months (the long-stay patients) and who remain in the nursing home for an average of 2.9 years.² Although long-stay patients are the minority of admissions, they represent the majority of patients in long-term care at any one time. This group of patients can be divided into three subgroups: (1) those with primarily functional dependencies, (2) those with primarily cognitive impairments, and (3) those with both. The distribution of patients into these subgroups is in constant flux, but weighted heavily toward the latter two. Up to 94% of patients in long-term care have some degree of mental impairment, mainly due to degenerative neurological diseases, multi-infarct dementia, depression, or delirium.¹⁴ However, those with

predominantly functional dependencies suffer major illnesses that require an increasingly more sophisticated level of service.

Specialization in long-term care

Long-term care beds in Maryland are divided between two broad levels of care. The vast majority of beds in Maryland are for comprehensive care and are monitored under regulations for long-term care. Services are defined by the expertise available within the facility. Care ranges from custodial to subacute with capabilities for enteral and parenteral therapies and with ancillary services similar to those available in ambulatory settings.

More intensive services are provided in chronic care hospitals, which operate under the same regulations as acute care hospitals but without the length-of-stay restrictions. Therefore, most of the highly technical, specialized units are housed in these facilities. The long-term care industry has responded with an impressive array of service delivery capabilities rivaling the care available in the acute care setting. One example is parenteral therapies for administering acute and chronic antibiotics and, in some facilities, parenteral morphine for the terminally ill and total parenteral nutrition. Ancillary services to support these technologies, such as laboratory and radiology services, are also available. These added services and technologies have led to the growing use of full-time physicians, with nurse practitioners and physician assistants, to provide on-site supervision and staff support.

The clinical demands and the expertise needed to provide these services have, in many instances, stimulated the establishment of specialized units. These units provide care under the direction of highly trained interdisciplinary teams with dedicated nursing and support staff. Affiliation with teaching hospitals and universities, as well as active research and educational programs, assure that the care is the best available. The advantage of housing such units in long-term care settings is that the services may be provided for as long as needed, without the constraints on length of stay imposed in acute care facilities—and at far less cost. Types of specialty units available in Maryland include Alzheimer's disease, geriatric rehabilitation, acquired immunodeficiency disease syndrome (AIDS) hospice, geropsychiatry, pressure sore management, ventilator assistance, and hospice and terminal care.

The physician in the nursing home

Nursing home medicine is becoming a recognized area of interest, even among geriatricians,^{15–17} and a financially viable setting for practice. The average nursing home patient has multiple, concurrent, and interactive medical and psychosocial problems requiring constant monitoring, therapeutic adjustment, and counseling. The medical conditions and clinical problems commonly encountered in the nursing home are rare in other settings (**Table 1**).

Table 1. Clinical problems common to the nursing home setting

- ◆ Falls, gait, and mobility disorders
- ◆ Behavioral disturbances
- ◆ Weight loss and nutritional disorders
- ◆ Enteral feedings
- ◆ Infectious diseases and multiple site colonizations
- ◆ Ethical issues in end-stage and terminal illnesses
- ◆ Iatrogenesis and polypharmacy
- ◆ Urinary incontinence and bowel disorders
- ◆ Pressure ulcers

Table 2. Revised reimbursement codes for nursing and hospital care

| Codes | Relative value units | 1992-1993 Increase |
|--|----------------------|--------------------|
| Initial nursing facility care codes | | |
| 99301 | 1.10 | 20% |
| 99302 | 1.76 | 51% |
| 99303 | 2.36 | 55% |
| Subsequent nursing facility care codes | | |
| 99311 | 0.56 | 10% |
| 99312 | 0.91 | 26% |
| 99313 | 1.23 | 16% |
| Initial hospital care codes | | |
| 99221 | 1.10 | |
| 99222 | 1.90 | |
| 99223 | 2.65 | |
| Subsequent hospital care codes | | |
| 99231 | 0.56 | |
| 99232 | 0.93 | |
| 99233 | 1.30 | |

Source: Medicare Program; Fee Schedule for Physicians' Services for Calendar Year 1993. Table 1. Federal Register. November 25, 1992. p. 55936.

The nurse-physician relationship in long-term care facilities is also different than that in the hospital or office setting, with the nurse being central to the clinical care. Regulations promulgated to assist the physician have resulted in multidisciplinary teams composed of clinical pharmacists, dietitians, therapists, social workers, and nurse specialists. Governmental and private sector scrutiny has led to spiraling demands to document the care given. Fortunately, payment codes for nursing home visits are among the few for which Medicare remuneration has increased; the reimbursement is now equivalent to that provided in the acute care setting (Table 2).

The increasing complexity of care in the nursing home and chronic hospital has dramatically changed the physician's role and responsibilities and requires physicians to keep current in the rapidly advancing field of geriatric medicine. The Medical and Chirurgical Faculty of Maryland (Med Chi) offers programs arranged by the Long-Term Care and Geriatrics Committee at Med Chi's annual and semiannual meetings. The American Geriatric Society (AGS), the American Medical Directors Association (AMDA), and the Gerontological Society of America (GSA) have assumed the leadership in continuing education in geriatric medicine, in helping physicians stay abreast of regulatory reform, and in negotiating with Medicare to assure that physicians receive adequate compensation for their work. The AGS and AMDA have Maryland affiliates; although the Maryland Gerontological Association focuses on

interdisciplinary programs, both Maryland affiliates help develop local networks, provide regional educational programs, and advocate at the state level.

The role of nursing home medical director has also changed. Care provided by a nursing home's medical staff is reviewed regularly through the Office of Licensing and Certification Programs. Concern about the quality of care^{18, 19} has led to recent regulations giving government agencies greater authority to impose sanctions on nursing homes for serious deficiencies, including medical care problems. Therefore, the medical director must be able to screen physicians who wish to practice in the facility, monitor the quality of the care provided, and remove practice privileges when warranted. The medical director is also responsible for defining appropriate practice parameters and providing educational programs for the medical staff.

AMDA has developed extensive materials to assist medical directors in establishing and running a medical staff organization. The Robert Wood Johnson Foundation has recently funded a program through the University of Maryland School of Medicine to develop clinical practice guidelines specific to the nursing home setting to assist medical directors in their educational and oversight roles. AMDA also sponsors a program that can lead to the title of certified medical director of a long-term care facility.

Conclusion

The emerging field of nursing home medicine presents many opportunities for primary and specialty care givers. The special clinical problems, ethical issues, and psychiatric concerns of patients in long-term care are being recognized. Many innovative programs have been established in Maryland facilities. Several organizations provide educational programs and professional support for physicians and other health care practitioners interested in advancing their careers in this challenging area.

References

1. Department of State Planning: Population Projections. *Office of Planning Data, Report 1A, Revisions*. September 1987.
2. Hing E, Sekscenski E, Strahan G. *The National Nursing Home Survey: 1985. Summary for the United States*. Vital & Health Statistics, Series 13, No 97, DHHS Pub No (PHS) 89-1785. Hyattsville, Maryland. National Center for Health Statistics: 1990.

3. Kemper P, Murtaugh CM. Lifetime use of nursing home care. *N Engl J Med* 1991;324:595-600.
4. Ouslander JG, Osterweil D, Morley J (eds). *Medical Care in the Nursing Home*. New York: McGraw-Hill, Inc. 1991.
5. Lewis MA, Cretin S, Kane RL. The natural history of nursing home patients. *Gerontologist* 1985; 25:382-88.
6. Shaughnessy PW, Kramer AM. The increased needs of patients in nursing homes and patients receiving home health care. *N Engl J Med* 1990; 322:21-27.
7. Sager MA, Easterling DV, Kindig DA, Anderson OW. Changes in the location of death after passage of Medicare's prospective payment system. *N Engl J Med* 1989; 320:433-39.
8. Iglehart JK. The American health care system—introduction. *N Engl J Med* 1992; 326:962-67.
9. *Managed Care Digest: Long-Term Care Edition*. Kansas City, Missouri: Marion Merrell Dow Inc. 1993.
10. Feather J, Karuza J. The funding of nursing home care. In: Katz PR, Calkins E (eds). *Principles and Practice of Nursing Home Care*. New York: Springer. 1988. pp. 15-22.
11. Kavesh WN. Home care: process, outcome, cost. *Annual Review of Gerontology Geriatrics* 1986; 6:135-95.
12. Personal communication from the Maryland Hospital Association.
13. Kane RA, Ouslander JG, Abrass IB. *Essentials of Clinical Geriatrics* (second edition). New York: McGraw-Hill International Book Co. 1989.
14. Rovner BW, Kafonek S, Phillips L, Lucas MJ, Folstein MF. Prevalence of mental illness in a community nursing home. *Am J Psychiatry* 1986; 143:1446-49.
15. Libow LS, Starer P. Care of the nursing home patient. *N Engl J Med* 1989; 321:93-96.
16. Ouslander JG. Medical care in the nursing home. *JAMA* 1989; 262:2582-90.
17. Starer P, Libow LS. Medical care of the elderly in the nursing home. *J Gen Intern Med* 1992; 7:350-62.
18. Vladek B. *Unloving Care: The Nursing Home Tragedy*. New York: Basic Books Inc. Publishers. 1980.
19. Institute of Medicine. *Improving the Quality of Care in Nursing Homes*. Washington, DC: National Academy Press. 1986.

Suggested readings

Katz PR, Calkins E (eds). *Principles and Practice of Nursing Home Care*. New York: Springer Publishing Co. 1989.

Levenson SA. *Medical Direction in Long-Term Care*. Baltimore, Maryland: National Health Publishing. 1988. ■



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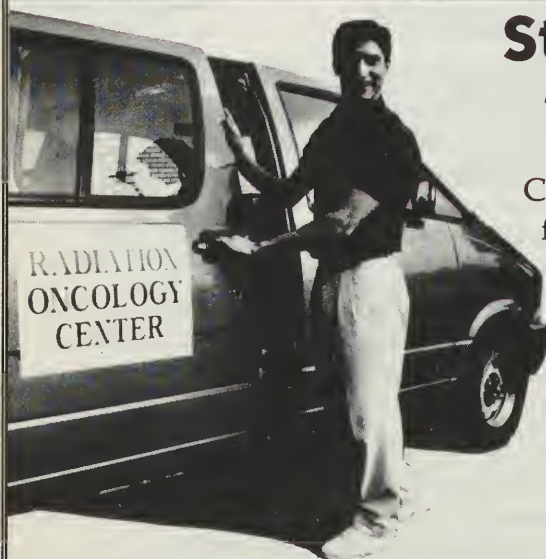
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Avoiding polypharmacy and iatrogenesis in the nursing home

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ABSTRACT: *The vast majority of nursing home patients over age 65 take at least one prescription medicine, and, on average, seven drugs are concurrently prescribed for each of these patients. One result of this polypharmacy is an increased risk of iatrogenic disease. The authors discuss traditional prescribing patterns in nursing homes and how these patterns contribute to drug-drug and drug-disease interactions in nursing home patients, as well as strategies to reduce polypharmacy and iatrogenesis.*

There have been few large scale studies that have described prescribing practices for elderly nursing home (institutionalized) patients in the United States. However, a consistent finding is that the vast majority of institutionalized patients over the age of 65 are taking at least one prescription medication.¹⁻⁷ (Table 1). Studies also report that, on average, seven drugs are concurrently prescribed for elderly nursing home residents.^{2,4,8} Up to a third of all nursing home residents may be prescribed eight or more drugs on a daily basis.⁹ Many of these medications are inappropriately prescribed.⁷

The most common classes of drugs prescribed for institutionalized elderly patients are analgesics or antipyretics, cardiovascular and antihypertensive medications, H₂ receptor antagonists, laxatives, antiseizure medications, and multivitamins¹⁰⁻¹² (Table 2). Up to one-half of the medications prescribed for nursing home patients are ordered on an "as needed" basis (prn). These are largely orders for sedatives, hypnotics, analgesics, and laxatives.^{1,13,14}

In 1989, retail prescription expenditures by the US elderly population were estimated to be in the range of \$9 billion, of which \$1 billion was expended on drugs for nursing home residents.¹⁵ Thus, the 5% of those over 65 years of age who are institutionalized account for almost 12% of the total retail expenditure for prescription drugs. Perhaps even more disconcerting is the report by the Institute of Medicine that quality of care in nursing homes,

Table 1. Prescribing patterns for elderly nursing home patients

| Country | Study design | Sample size | # receiving at least one drug | # drugs per patient |
|-----------|---|-------------|--|---------------------------|
| USA | Examination of record cards for randomly selected patients in one nursing home ¹ | 100 | - | 6.3/day |
| USA | Review of drug charts for all patients in one nursing home ² | 106 | - | 7.2 |
| USA | Comparison of drug use in patients in 173 nursing homes with drug use of patients in their own homes ³ | 5,902 | 97 | 67 prescriptions per year |
| USA | Review of drug charts over one year in three nursing homes ⁴ | - | - | 7.1 |
| UK | Study of drugs prescribed in 18 nursing homes ⁵ | 400 | - | 3.0 |
| Australia | Study of drugs prescribed in eight private nursing homes ⁶ | 250 | 79 | 3.0 |
| USA | Study of drugs prescribed in 12 nursing homes ⁷ | 1,106 | 40% had been prescribed at least one inappropriate medication. 10% had been prescribed two or more inappropriate medications. All prescriptions received by 7% were inappropriate. | |

Modified from Nolan L, O'Malley K. Prescribing for the elderly: Part II; prescribing patterns: differences due to age. *J Am Geriatr Soc* 1988; 36:249 (Table 3).

including drug prescribing patterns, is not satisfactory,¹⁶ and that multiple drug use is a risk factor for adverse drug reactions and iatrogenesis in elderly patients.

Polypharmacy and iatrogenesis

Older institutionalized patients have an increased prevalence of disease that makes the use of medications riskier;

yet the presence of diseases necessitates use of medications. Furthermore, the drugs that are most commonly implicated in causing adverse drug reactions are the ones that are most often prescribed for elderly institutionalized patients; these include digoxin, warfarin, insulin, and antiarrhythmics. Thus, iatrogenesis caused by medications may, in some part, reflect the advanced age of the patients

and the presence and severity of their concomitant medical disorders, as well as the types of medications prescribed. Indeed, those 65 years of age and over face twice the risk of iatrogenic disease as do younger persons.¹⁷ This may be because of altered drug action in the elderly,^{18,19} undetected malnutrition that may change drug action, or use of drugs for which there is no clear indication.

Table 2. The most often prescribed drugs to elderly nursing home residents

| 1981 ⁹ | 1988 ¹⁰ | 1991 ¹¹ |
|-------------------------|---------------------------------|----------------------------------|
| Hydrochlorothiazide | Digoxin | Acetaminophen |
| Digoxin | Furosemide | Aspirin |
| Furosemide | Potassium supplement | Captopril |
| Aspirin | Dipyridamole | Ranitidine |
| Potassium supplement | Nitroglycerin | Laxatives |
| Triamterene | Haloperidol | Hydantoin |
| Vitamin B ₁₂ | Thioridazine | Ibuprofen |
| Papaverine | Hydrochlorothiazide/triamterene | Digoxin |
| Isosorbide dinitrate | | Potassium supplement |
| | | Multivitamins |
| | | Calcium supplement |
| | | Propoxyphene/APAP(acetaminophen) |

The major risk factor for adverse drug effects and drug interaction is multiple drug use.²⁰ Adverse drug reactions and interactions rise exponentially with the number of drugs a patient receives,^{20,21} particularly when drugs are prescribed on an as needed basis. In addition to an increased risk for drug-drug interactions when multiple drugs are prescribed, there is an increased risk of drug-disease interactions. For example, beta blockers as a treatment for neuroleptic-resistant psychosis may exacerbate asthma, congestive heart failure (CHF), or atrioventricular (A-V) conduction defects. Finally, multiple medications may lead to use of drugs with different therapeutic effects but the same side effect profile, resulting in cumulative toxicities.^{20,21}

Given this background, the terms "polymedicine" and "polypharmacy" more nearly fit the definition of "unnecessary drugs" as described in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).^{22,23} These terms pertain to medications that are given in excessive doses, for excessive periods of time, without adequate monitoring, or without diagnosis or behavioral justification. While there are no conclusive data, unnecessary drugs are probably responsible for adverse drug effects and interactions in perhaps 5% to 10% of nursing home residents.

Concern about the questionable use of medications and subsequent side effects among long-term care patients has centered on the psychotropic agents. Misuse of psychotropic drugs in nursing homes has long been suggested and confirmed.^{3,24,25} Side effects associated with these agents include sedation, apathy, withdrawal, depressed mood, and confusion, especially among patients with a preexisting dementia.²⁶ Furthermore, most of these agents cause peripheral anticholinergic blockade with resultant constipation, atonic bladder, and prostatic hypertrophy. These agents also commonly cause orthostatic hypotension together with tachycardias, cardiac arrhythmias, and conduction disturbances. Prolonged use of major tranquilizers are also associated with a high incidence of extrapyramidal side effects and, in some cases, tardive dyskinesia.²⁷

Advanced age and neuroleptic exposure contribute to significantly greater motor instability than would be expected by either factor alone.²⁸ Among people residing in a nursing home, the predictors of falling during an observation period of one year included hip weakness, poor balance, and taking more than four medications. Each patient who had all three of these risk factors fell during the follow-up period. It is estimated that the fall rate in nursing homes is 1,600 falls per 1,000 beds per year, and that falls constitute the majority of deaths by injury in persons over the age of 65.

Other drugs commonly associated with adverse drug reactions in elderly institutionalized patients include beta blockers, calcium channel blockers, antihypertensives (methyldopa), furosemide and other diuretics, nonsteroidal anti-inflamma-

tory drugs, benzodiazepines, and theophylline.²⁹ With these drugs, the elderly patient is more prone to an adverse reaction from inappropriate drug dosing, suggesting that altered pharmacokinetics and pharmacodynamics may be causative.³⁰ There is good evidence that alterations in drug metabolism, renal elimination, and drug distribution occur more commonly in the elderly and result in higher serum and tissue concentrations of certain medications.³¹ This is particularly true for drugs that are predominantly eliminated by renal excretion and for medications whose plasma concentration is dependent on altered age-related volumes of distribution. Lipid-soluble drugs, such as diazepam, have prolonged durations of action because of longer elimination half-lives in the elderly. The half-life of diazepam increases linearly from 20 hours at 20 years of age to 90 hours in those over 80 years of age.³² By contrast, water-soluble drugs, such as digoxin, cimetidine, and alcohol, reach higher initial concentrations in the plasma as a result of age-related decreases in total body water and lean body mass.³⁰

The effect of drugs at a target site has been less carefully evaluated in elderly patients. There is, however, evidence that both increased and decreased receptor sensitivity occurs. The elderly appear to be more sensitive to the effects of medications such as warfarin and benzodiazepines but significantly less sensitive to the effects of calcium channel blockers and beta blockers. In both situations, adverse drug effects may result.

Strategies to reduce polypharmacy and iatrogenesis

Several approaches to polypharmacy problems have been developed for the long-term care setting. These include national policies based on regulatory reform; regular review and analysis of indications for medication use; and regional or local adoption of clinical practice guidelines.

Regulatory reform. OBRA 1987 promulgates federal regulations for neuroleptic drugs in Medicaid- and Medicare-certified nursing homes. These regulations were implemented on October 1, 1991,²² and specify, for the first time, that prescription drugs must be justified by indications documented in the medical chart. The section on antipsychotics consists of four components: (1) documentation of a specific condition, including psychiatric diagnoses that warrant neuroleptic use; (2) prohibition of neuroleptics if certain behaviors (such as yelling or wandering) are the only justifications; (3) prohibition of neuroleptic use on an as-needed basis; and (4) gradual dose reduction coupled with attempts at behavioral programming, including environmental modification.²³ The regulations seem to have had a beneficial effect.¹⁴ Haloperidol and thioridazine usage in nursing homes for the treatment of all senile conditions dropped from 55,000 mentions* in October 1990 to 21,000 mentions in November 1991—a 62% decrease.

*Drug mentions represent drugs prescribed, recommended, or administered in any medical setting by a private physician who has an office-based practice. Mentions reflect usage but should not be interpreted as being equivalent to prescriptions or patients.

Table 3. Strategies to reduce inappropriate drug prescribing to nursing home patients

| Medicine class | Strategy |
|---|---|
| Antibiotics | |
| oral antibiotics | Therapy for more than four weeks should be avoided except when treating osteomyelitis, prostatitis, tuberculosis, or endocarditis. |
| Antidepressants | |
| amitriptyline | Use should generally be avoided. Use a less anticholinergic antidepressant such as nortriptyline. |
| Combination antidepressants and antipsychotics | |
| Triavil (perphenazine/amitriptyline) | Use should generally be avoided. If needed, prescribe individual components at appropriate doses for elderly people. |
| Antipsychotics | |
| haloperidol | Doses of more than 3 mg/day should be avoided. Patients with known psychotic disorders may require higher doses. |
| thioridazine | Doses of more than 30 mg/day should be avoided. Patients with known psychotic disorders may require higher doses. |
| Cognitive enhancers | |
| cyclandelate | All use should be avoided. Effectiveness is in doubt. |
| isoxsuprine | All use should be avoided. Effectiveness is in doubt. |
| H₂ receptor antagonists | |
| cimetidine | Doses of more than 900 mg per day and therapy for longer than 12 weeks should be avoided. |
| ranitidine | Doses of more than 300 mg per day and therapy for longer than 12 weeks should be avoided. |
| Nonsteroidal anti-inflammatory drugs (NSAIDs) | |
| indomethacin | Use should generally be avoided. Other NSAIDs exhibit less central nervous system toxicity. |
| phenylbutazone | All use should be avoided. Other NSAIDs are less toxic. |
| Oral hypoglycemics | |
| chlorpropamide | All use should be avoided. Other oral hypoglycemics have shorter half-lives and do not cause SIADH (syndrome of inappropriate secretion of antidiuretic hormone). |
| Platelet inhibitors | |
| dipyridamole | All use should be avoided. Effectiveness at low doses is in doubt. Toxicity is high at higher doses. Aspirin is a safer alternative. |
| Sedative hypnotics | |
| <i>Long-acting benzodiazepines:</i> | |
| chlordiazepoxide | Should usually be avoided. Use short-acting benzodiazepines if needed. |
| diazepam | Should usually be avoided. Use short-acting benzodiazepines if needed. |
| flurazepam | Should usually be avoided. Use short-acting benzodiazepines if needed. |
| meprobamate | All use should be avoided, except in those who are already addicted. |
| <i>Short-acting benzodiazepines:</i> | |
| alprazolam | Nightly use for more than four weeks should be avoided. |
| oxazepam | Any single dose of more than 30 mg should be avoided. |
| triazolam | Any single dose of more than 0.25 mg should be avoided. |
| <i>Short-duration barbiturates:</i> | |
| pentobarbital | All use should be avoided, except in those who are already addicted. Safer sedative hypnotics are available. |
| secobarbital | All use should be avoided, except in those who are already addicted. Safer sedative hypnotics are available. |

Modified from Beers MH. Polypharmacy and Appropriate Prescribing. In: Beck JD (ed). *Geriatric Review Syllabus: A Core Curriculum in Geriatric Medicine*. New York: American Geriatrics Society. 1991-1992. pp. 218-24.

Table 4. An approach to optimal drug use in nursing homes

| Overall factors | Clinical questions and issues |
|-------------------------------|---|
| History | Underlying medical illness? Are symptoms drug-induced? Are there prior psychiatric symptoms? How were they treated? Was it effective? If drug was used, what were the side effects? |
| Physical status | Any neurologic, renal, or hepatic dysfunction that may predispose patient to adverse drug reactions? |
| Mental status | Is psychiatric illness of recent onset? Is there evidence of dementia or delirium? |
| Social status | Does patient have or need a social support system? |
| Concomitant drugs | If psychotropic drug is prescribed, what are potential interactions with prescribed and over-the-counter drugs? |
| Monitoring drug | What should be monitored (e.g., early signs of tardive dyskinesia)? How often? By who? |
| Therapeutic endpoint | Has the therapeutic endpoint been defined before prescribing? (The partial improvement, rather than total elimination of symptoms, is often realistic and acceptable.) |
| Stop date | Is a stop date indicated and noted in the patient's record? |
| Recently released medications | Are the effects of these medications fully known in elderly patients? |
| As needed (prn) medications | Is there ongoing monitoring about indications for use and decisions about use? |
| Compliance | Is there communication with patient and staff, written instructions, and schedules of drug administration? |

Clearly, regulations can be effective, but are not applicable in all situations. In a retrospective study in which the new OBRA regulations were applied to randomly selected residents in 60 nursing homes, it was found that one-half of all neuroleptic use would still be inappropriate under the new regulations.³³ Another recent study found that almost 20% of nursing home residents were exposed to potentially excessive neuroleptic use. The use of these drugs was inversely proportional to the staff-to-resident ratio and reimbursement status of the residents.³⁴

Review and analysis of indications for medication use. Explicit criteria for drug use can be established for a particular facility similar to those recently published.³⁵ For individual drug classes, more intensive regular reevaluation of indications for continued use should be implemented³⁶ (Table 3). However, discontinuing medicines for nursing home patients, although useful in reducing iatrogenesis, is not always easy. Older patients often accumulate medicines whose original indications have been forgotten or no longer exist or that are not compatible with current prescribing practices. This is especially true in nursing home patients who are treated over time in a variety of settings (e.g., one or more nursing homes, hospitals, or offices) and by many physicians. Often information about these encounters is lost, and patients either cannot remember or were never told why a medicine was prescribed. Physicians are often reluctant to stop medicines in a patient who is stable for fear of causing clinical deterioration.

The most common offender in this category is digoxin. Many studies have demonstrated that digoxin can be safely withdrawn in a large proportion of elderly patients, especially in cases where there are no clear-cut indications for ongoing use.³⁷ This has been demonstrated in nursing home patients as well.^{38,39} Digoxin has been associated with serious side effects that are particularly troublesome in nursing

home patients, including anorexia and depression. Criteria to determine appropriate patients for withdrawal of digoxin are available.⁴⁰

Institution-specific quality improvement. It is increasingly clear that treatment of disease is not the only desirable outcome of drug therapy for nursing home residents. Because patients may reside in a nursing home for an extended period of time, their ability to function and their quality of life are equally important. The National Institute on Aging has suggested that an interactive team of professionals can best address these problems.³⁵ With regard to drug therapy, the team would consist of the physician, a nurse, and the consultant pharmacist. The role of a clinical pharmacist in institutional settings may include developing or updating institutional formularies, coordinating pharmacy and therapeutics committees (which can be incorporated into regular staff meetings in smaller homes), performing drug use audits, and providing feedback to physicians through clinical pharmacy reviews. Nurse practitioners and physician assistants have been shown to be effective members of pharmacy and therapeutics committees, and a dietician and other health care professionals may be called upon as well. Risk factor elimination, the proper nutritional approach, and other nonpharmacologic measures should always precede the decision to use drugs.

There should be standard drug-dispensing methods that are consistent with known facts about a particular drug. The patient and the patient's family should be part of the prescribing and dispensing process as much as possible. In prescribing, the risk factors approach (Table 4)—to eliminate cumulation of side effects—should be used.⁴¹ Computer software, such as the one on drug interactions from the *Medical Letter*, can be very helpful. An efficient system for prescribing and reviewing medication use and communicating any concerns is essential.

References

- Kalchthaler T, Coccaro E, Lichtiger S. Incidence of polypharmacy in a long-term care facility. *J Am Geriatr Soc* 1977; 25:308-13.
- Bergman HD. Prescribing of drugs in a nursing home. *Drug Intelligence and Clinical Pharmacy* 1975; 9:365-68.
- Ray WA, Federspiel CF, Schaffner W. A study of antipsychotic drug use in nursing homes: Epidemiological evidence suggesting misuse. *Am J Public Health* 1980; 70:485-91.
- Rawlings JL, Frisk PA. Pharmaceutical services for skilled nursing facilities in compliance with federal regulations. *Am J Hosp Pharm* 1975; 32:905-08.
- Primrose WR, Capewell AE, Simpson GR, et al. Prescribing patterns observed in registered nursing homes and long-stay geriatric wards. *Age Ageing* 1987; 16:25.
- Smithurst BA. Consumption of drugs in eight private nursing homes in a provincial Australian city. *Public Health* 1982; 96:292.
- Beers MH, Ouslander JG, Fingold SF, et al. Inappropriate medication prescribing in skilled nursing facilities. *Ann Intern Med* 1992; 117:684-94.
- Segal JL, Thompson JF, Floyd RA. Drug utilization and prescribing patterns in a skilled nursing facility: The need for a rational approach to therapeutics. *J Am Geriatr Soc* 1979; 27:117-22.
- Lamy PP. New dimensions and opportunities. *Drug Intelligence Clinical Pharmacy* 1985; 19:399-402.
- Lamy PP. Patterns of prescribing and drug use. In: Butler RN, Bearn AG (eds). *The Aging Process: Therapeutic Implications*. New York: Raven Press. 1985. pp. 53-82.
- Lamy PP, Michocki RJ. Medication management. *Clin Geriatr Med* 1988; 4(3):623-38.
- Feinberg M. Personal communication on unpublished long-term care drug use data. 1991.
- Howard JB, Strong KE, Strong SE. Medication procedures in a nursing home: abuse of PRN orders. *J Am Geriatr Soc* 1977; 25:83-84.
- Aycock EK. PRN drug use in nursing homes. *Am J Hosp Pharm* 1981; 38:105.
- National Disease and Therapeutic Index: A Medical Profile of the Over-65 Population*. Plymouth Meeting, Pennsylvania: IMS America. 1991.
- Institute of Medicine. *Improving the Quality of Care in Nursing Homes*. Washington, DC: Academy Press. 1986.
- Jahningen D, Hannon C, Laxson L, et al. Iatrogenic disease in hospitalized elderly veterans. *J Am Geriatr Soc* 1982; 30:387-90.
- Lamy PP. Physiological changes due to age: pharmacodynamic changes of drug action and implications for therapy. *Drugs and Aging* 1991; 1:385-404.
- Lamy PP, Lesko LJ. Altered drug action in the elderly. In: Bailey DM (eds). *Annual Reports in Medical Chemistry* 1985; 20:295-313.
- Lamy PP. The elderly and drug interactions. *J Am Geriatr Soc* 1986; 34:586-92.
- Lamy PP. Adverse drug effects. *Clin Geriatric Med* 1990; 6(23):293-307.
- Health Care Financing Administration. Medicare and Medicaid: requirements for long-term care facilities. Final rule with requests for comments. *Federal Register* 1989; 54:5316-36.
- Omnibus Budget Reconciliation Act of 1987. Public Law 100-203, Sections 4201 (a), 4211 (a).
- Blazer DG, Federspiel CF, Ray WA, et al. The risk of anticholinergic toxicity in the elderly: a study of prescribing practices in two populations. *J Gerontol* 1983; 38(1):31-35.
- Beers M, Avorn J, Soumerai SB, et al. Psychoactive medication use in intermediate-care facility residents. *JAMA* 1988; 260:3016-20.
- Steel K, Gertman PM, Crescenzi C, et al. Iatrogenic illness on a general medical service at a university hospital. *N Engl J Med* 1981; 304:638-42.
- Jencks SF, Clauser SB. Managing behavior problems in nursing homes. *JAMA* 1991; 265:520-23.
- Caligiuri MP, Lohr JB, Jeste DV. Instrumental evidence that age increases motor instability in neuroleptic-treated patients. *J Gerontol* 1991; 46:B197-200.
- Grymonpre RE, Mitenko PA, Sitar DS, Aoki FY, Montgomery PR. Drug-associated hospital admissions in older medical patients. *J Am Geriatr Soc* 1988; 36:1092-98.
- Montamat SC, Cusack BJ, Vestal RE. Management of drug therapy in the elderly. *N Engl J Med* 1989; 321(5):303-9.
- Nolan L, O'Malley K. Prescribing for the elderly: Part I: sensitivity of the elderly to adverse drug reactions. *Am Geriatr Soc* 1988; 36:142-49.
- Klotz U, Avant GR, Hoyumpa A, et al. The effects of age and liver disease on the disposition and elimination of diazepam in adult man. *J Clin Invest* 1975; 55:347-359.
- Garrard J, Makris L, Dunham T, et al. Evaluation of neuroleptic drug use by nursing home elderly under proposed Medicare and Medicaid regulations. *JAMA* 1991; 265:463-67.
- Svarstad BL, Mount JK. Nursing home resources and tranquilizer use among the institutionalized elderly. *J Am Geriatr Soc* 1991; 39:869-75.
- Beers MH, Ouslander JG, Rollinger I, et al. Explicit criteria for determining inappropriate medication use in nursing home residents. *Arch Intern Med* 1991; 151:1825-32.
- Beers MH. Polypharmacy and appropriate prescribing. In: Beck JD (ed). *Geriatric Review Syllabus: A Core Curriculum in Geriatric Medicine*. New York: American Geriatrics Society. 1991-1992. pp. 218-24.
- Papadakis MA, Massie BM. Appropriateness of digoxin use in medical outpatients. *Am J Med* 1988; 85:365-68.
- Fonrose HA, Ahlbaum N, Bugatch E, Cohen M, Genovese C, Kelly J. The efficacy of digitalis withdrawal in an institutional aged population. *J Am Geriatr Soc* 1974; 22:208-11.
- Wilkins CE, Khurana MS. Digitalis withdrawal in elderly nursing home patients. *J Am Geriatr Soc* 1985; 33:850-51.
- Ahronheim JC. *Handbook of Prescribing Medications for Geriatric Patients*. Boston: Little, Brown, and Company. 1992. p. 200.
- Michocki RJ, Lamy PP. A "risk" approach to adverse drug reactions. *J Am Geriatr Soc* 1988; 36:79-81. ■

Delirium

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ABSTRACT: *Delirium, a common psychiatric disorder in the elderly, can be difficult to identify. This article describes the two central features of delirium: diminished cognitive capacity and altered levels of consciousness. Treatment and research into the mechanisms of delirium are discussed.*

Delirium is a common psychiatric disorder in the elderly. In spite of its high prevalence, however, most clinicians find delirium difficult to identify or even define. Its frequency was highlighted in a recent article¹ that found that 10.5% of the elderly admitted to the general floors of an acute hospital suffered from delirium at the time of admission and an additional 31.3% developed a delirium while hospitalized. The difficulty in recognizing delirium is reflected by studies showing that cognitive disorders in hospitalized patients are often not identified.²

According to the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition-Revised (*DSM-III-R*),³ the "essential features of delirium are reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli, and disorganized thinking, as manifested by rambling, irrelevant, or incoherent speech." The *DSM-III-R* also lists secondary criteria such as altered levels of consciousness, altered sleep-wake cycles, changes in activity levels, and misperceptions and hallucinations. Unfortunately, many clinicians find this definition difficult to grasp and difficult to apply.

From this writer's perspective, delirium has two central features. First, the patient's cognitive capacity is diminished. Memory, orientation, and other intellectual functions are impaired when compared with the patient's baseline functioning. Thus, a cognitive assessment is a necessity in diagnosing delirium; the high prevalence of delirium demonstrates the need to assess elderly patients' cognitive function as part of a standardized assessment.

Delirium's second central feature, which is harder to characterize in words, is an altered level of consciousness or attention. Generally, delirious patients do not appear alert and attentive. They are often drowsy, frequently lose track of conversations, and are unable to follow a line of reasoning that would normally be within their capacity to follow. Occasionally, patients with delirium are hypervigilant and more attentive than usual. In this state, patients are startled by the slightest noise or quickly turn their attention to any change in the environment—for example, a noise in the hallway that an examiner may not notice. Clinicians often note these latter changes before cognitive impairment is obvious. It is important to follow up such suspicious clinical indications with a standardized clinical assessment.

The number of psychiatric symptoms associated with delirium have been reported at different rates in different studies. These symptoms are not necessary for the diagnosis of delirium, but their occurrence should raise suspicion about delirium, and delirium should be included in the differential diagnosis. These symptoms include misperceptions, hallucinations, suspicions or delusions, changes in physical activity levels (e.g., becoming more active or more withdrawn than usual), and altered sleep patterns.

In the past, delirious states were sometimes labeled with names suggesting a link to specific medical conditions. Recent examples are postcardiotomy delirium and black-patch psychosis. However, evidence dating back 50 years suggests that delirium may be a single clinical syndrome with many different etiologies. Thus, metabolic, infectious, structural, focal, and systemic diseases can all cause the symptoms included under the rubric of delirium. It remains unclear, however, whether there are subtypes of delirium.

Some writers have suggested that two subtypes of delirium are distinguished by activity level (hypoactivity or hyperactivity) or by the direction in which the level of consciousness is altered (hypovigilant or hypervigilant), may be symptomatically or phenomenologically different, and may reflect different neural substrates.⁴ Since the evidence is mixed on whether there is any specific subtype in delirium, this writer suggests that clinicians rely on the single category of delirium and include a variety of different behavioral types within it until the scientific evidence points more clearly in one direction.

Another reason for clinical discomfort with the category of delirium is the lack of conviction that its recognition relates to medical practice. Nothing could be further from the truth. A request by the nursing staff for a psychotropic agent, a soporific, or a restraint or protective device should prompt consideration of delirium and trigger a search for a specific etiology, especially the onset of a new illness. Whether the changes in cognitive performance and level of consciousness or alertness are superimposed on a previously impaired cognitive system (i.e., dementia) or occur in an

individual who was cognitively and medically normal prior to the development of these changes, their development signals a change in physiology. The process responsible for these changes is often treatable, and early recognition may diminish the underlying etiologic condition. Also, prompt recognition of delirium can diminish significant patient distress.

Treatment

The identification of delirium should immediately trigger a search for its cause or causes. Because the differential diagnosis is a long one, no standardized assessment covering all etiologies can be recommended. However, all patients with delirium should have a physical examination to identify specific causes. The list of potential etiologies is long, but the most common causes—metabolic imbalance, medication intoxication, and drug withdrawal—are fully reversible, as are many less common etiologies.

A knowledge of the patient's underlying medical condition, medications, drug and alcohol history, and toxic exposure history often helps in identifying likely etiologies. Because metabolic and infectious disorders are the most frequent causes, all patients with the diagnosis of delirium should undergo a chemistry screen, complete blood count (CBC), urinalysis, and chest x-ray; thyroid function studies should be obtained if not recently documented. An electroencephalogram (EEG) is useful in confirming the diagnosis. It can also be used as an objective means of following the patient since it mirrors the clinical course.

While identifying a specific etiology is important, since it often directs the medical therapy, a specific etiology is not always found. Moreover, even when the etiology is found, it often takes days or even weeks for the abnormality to be treated and corrected. Thus, management strategies to relieve patient distress and the associated behavioral problems are essential.

Many patients find delirium frightening. Disorientation and the inability to remember what has just happened, as well as hallucinations, suspicions, and delusions, cause significant distress to delirious patients and to those providing care. Little research has been done on managing these symptoms, but there appears to be consensus among clinicians on several approaches:

- ◆ Frequent reassurance, explanation, and reorientation help remind patients where they are, why they are there, and what is happening.
- ◆ A moderate level of stimulation is reassuring. Complete darkness often worsens hallucinations, misperceptions, and delusions. Conversely, overly bright lights and constant loud noises can be distressing. An environment in which ambient light and noise are moderate, but not overstimulating, appears best.

- ♦ Frequent contact with health care providers, family members, and aides helps dispel the depression and fear that many patients experience.
- ♦ Low-dose neuroleptic drugs are indicated when hallucinations and delusions become persistent or frightening or when behavior is life-threatening. Although there have been no adequately designed control studies to support the use of these potent drugs, a consensus does exist on their utility; 1 mg of haloperidol is most commonly recommended.

Research into underlying mechanisms

Theories about mechanisms of delirium tend to focus on the reticular activating system and other brain pathways or neurotransmitter systems that maintain attention, concentration, and level of consciousness.^{4,5} Our present understanding of these systems is primitive, and this has hampered studies of potential mechanisms. Complicating mechanism studies further are the complexities involved in identifying delirium, the fact that patients in delirious states are acutely medically ill, and a lack of appreciation of the high prevalence of delirium.

Several research groups have begun focusing on improving methods of identifying delirium and on its epidemiology. Two recent volumes^{6,7} provide the interested reader with accessible summaries of current thinking about delirium.

References

1. Levkoff SE, Evans DA, Liptzin B, et al. Delirium: the occurrence and persistence of symptoms among elderly hospitalized patients. *Arch Intern Med* 1992; 152:334-40.
2. Knights EB, Folstein MF. Unsuspected emotional and cognitive disturbance in medical patients. *Ann Intern Med* 1977; 87:723-24.
3. *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition, Revised). Washington, DC: American Psychiatric Association. 1987.
4. Ross CA. CNS arousal systems: possible role in delirium. *International Psychogeriatrics* 1991; 3:353-71.
5. Gibson GE, Blass JP, Huang H-M, Freeman GB. The cellular basis of delirium and its relevance to age-related disorders including Alzheimer's disease. *International Psychogeriatrics* 1991; 3(2):373-95.
6. Lipowski ZJ. *Delirium: Acute Brain Failure in Man* (Second Edition). New York: Oxford. 1990.
7. Cohen GD. *Delirium: Advances in Research and Clinical Practice*. New York: Springer Publishing Company. Winter 1991. ■

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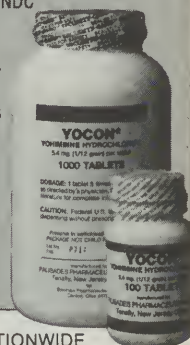
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The management of urinary incontinence in the long-term patient

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ABSTRACT: *Urinary incontinence affects 50%–80% of residents in nursing homes, presenting a challenge to the health care team. Assessment of urinary incontinence is crucial to selecting appropriate treatment. This article addresses the scope of the problem, incontinence assessment, and treatment specific to nursing home residents.*

Urinary incontinence is defined as “a condition where involuntary loss of urine is a social or hygienic problem and is objectively demonstrated.”¹ In long-term care facilities, urinary incontinence presents a challenge to the health care team. Each nursing home resident with urinary incontinence should be assessed to facilitate appropriate treatment selection. The first section of this article discusses the scope of the problem of urinary incontinence. The last two sections address options for evaluating and treating urinary incontinence in long-term care residents.

Scope of the problem

In 1988, the National Institutes of Health (NIH) held a consensus conference on urinary incontinence (UI). Several conclusions were drawn:²

- ♦ *UI is very common among older Americans and is epidemic in nursing homes.* It is estimated that at least 10 million adult Americans suffer with urinary incontinence. In the nursing home population, prevalence rates have been reported between 50% and 80%.^{3,4}
- ♦ *UI costs Americans more than \$10 billion each year.* Urinary incontinence has been cited as a major reason for nursing home placement. The annual cost of providing treatment for incontinence in nursing homes has been estimated to be as high as \$3.3 billion.⁵ A continued rise in the cost of treating incontinence can be expected if changes are not made in the management of the problem.
- ♦ *UI is not part of normal aging, but age-related changes predispose individuals to the condition.* The wear and tear of aging does not

spare the lower urinary tract. Anatomic and physiologic insults predispose the elderly to urinary incontinence. Iatrogenic factors also place the elderly at higher risk for urinary incontinence.⁶

- ♦ **Contrary to public opinion, most cases of UI can be cured or markedly improved.** Treatment options include behavioral or educational techniques, medication, and surgery. Schnelle and colleagues demonstrated that a behavioral management approach significantly reduces the frequency of urinary incontinence with a 45% increase in appropriate use of the toilet in an institutionalized geriatric population.⁷
- ♦ **Of the 10 million Americans with UI, more than half have not been evaluated or treated.** Patients often do not disclose their incontinence symptoms because they are embarrassed or believe that it is a normal consequence of aging. Efforts have been made to increase public awareness and alert sufferers that urinary incontinence should be discussed with a physician.
- ♦ **Every person with UI should be evaluated and considered for treatment.** To date, research and treatment for the incontinent elderly have been carried out mainly in specialized continence clinics. It is now appropriate that these protocols be incorporated into clinical practice.

Evaluating incontinence

The Resident Assessment Protocol (RAP) issued by the Health Care Financing Administration (HCFA) addresses the importance of an incontinence evaluation for long-term care residents. *The Clinical Practice Guidelines for Urinary Incontinence in Adults*, recently published by the Agency for Health Care Policy and Research (AHCPR), provides a method to

systematically evaluate long-term care residents.⁵ The evaluation involves a team effort.

History. An incontinence history should include the onset, duration, and frequency of incontinent events. Sudden onset of acute incontinence or urinary symptoms such as dysuria and straining on urination are usually associated with an acute medical problem.⁸⁻¹⁰ Potential causes of new onset incontinence can be identified by using the acronym "DRIP," a method developed by Ouslander et al.^{8,9}

D - Delirium

R - Restricted mobility; acute urinary retention

I - Infection, inflammation, fecal impaction

P - Pharmaceuticals; polyuria

Identifying and resolving acute urinary incontinence often results in restoration of continence.^{9,10}

Persistent or established incontinence may evolve from an unrecognized episode of acute incontinence. Clinical patterns of persistent incontinence are stress, urge, overflow, and functional incontinence (**Table 1**). Persistent urinary incontinence may present as one pattern, but frequently there are two or more patterns, most commonly stress and urge incontinence.^{9,11,12}

Another incontinence pattern described by Resnick, detrusor hyperreflexia with impaired contractility (DHIC),¹³ is common in nursing home residents and is found through urodynamic testing. The bladder is overactive and does not empty adequately. Nursing home residents may exhibit symptoms of urge incontinence in addition to straining on urination in an effort to complete emptying.³

In the cognitively impaired nursing home resident, it may be difficult to elicit urinary symptoms. Nursing staff can contribute vital information because of their daily observation of a resident's behavior associated with an incontinent event and

Table 1. Persistent incontinence

| Patterns | Symptoms presented | Causative factors |
|----------------------------|--|--|
| Stress | Usually small urine leakage associated with laughing, bending, or lifting. | Urethral sphincter incompetence: weakened pelvic floor musculature, changes in anatomical position, urethral inflammation, or decrease in sphincter innervation. |
| Urge(detrusor instability) | Inability to hold urine when urge presents; usually large urine leakage. | Infection, inflammation, bladder stones, or tumors. Stroke, dementia, Parkinson's disease (termed detrusor hyperreflexia when associated with a neurologic condition). |
| Overflow | Feeling of incomplete bladder emptying, dribbling, or urge to urinate shortly after voiding. | Outlet obstruction (enlarged prostate, severe pelvic prolapse) or neurogenic atonic bladder. |
| Functional | Difficulty with ambulation and dexterity in manipulating clothing; inability to get to the toilet. | Physical, environmental, or psychological factors. |

the resident's capability to use the toilet. Many long-term care facilities use a record to monitor schedules of toilet use or incontinent events. These provide invaluable assessment information.

The patient's medical history should be reviewed for conditions that may be associated with urinary incontinence, such as diabetes mellitus, cerebral vascular accident, or degenerative neurological disease, which can affect bladder function and mobility.^{5,8,14} All medications should be reviewed to rule out pharmacologic causes of incontinence; the more common drugs associated with incontinence include anticholinergics, diuretics, sedatives and hypnotics, alpha antagonists, alpha agonists, and calcium channel blockers.^{5,10,15} Caffeine can also act as a bladder irritant and diuretic and, therefore, should be avoided.

A history focused on surgeries of the genitourinary, gynecological, and neurological systems is important.^{5,9,12} Any surgery affecting mobility could also affect continence status by limiting access to toilet facilities.

A urological history should focus on repeated urinary tract infections, bladder or kidney stones, bladder cancer, or use of a Foley catheter or straight catheter. Information concerning past urologic workup is also helpful.⁵

In summary, the history provides an overview of the individual's past and present continent status and factors possibly associated with incontinence. This information and the physical examination are essential in selecting the most appropriate treatment.

Examination. The physical examination provides crucial information. It is especially important since an accurate history may be difficult to obtain in patients with dementia.

The neurological examination should include an evaluation of cognitive status.¹¹ Impaired cognitive function can impair an individual's ability to use the toilet because of the failure or inability to communicate the need to use the toilet or because bodily sensations are misinterpreted. The evaluation should also include assessment of sensation in the perineal and lower extremities, gait, deep tendon reflexes, and anal wink.^{5,12}

An abdominal and suprapubic examination can rule out tenderness, masses, or bladder distention. The rectal exam should assess sphincter tone, prostate size and consistency, and masses or fecal impaction.^{5,10,12}

In females, the pelvic examination can identify signs of atrophic vaginitis or urethritis that may precipitate incontinence.^{9,15,16} The presence of pelvic prolapse should also be noted and quantified.⁵ The skin of the perineal area should be examined for signs of trauma, rashes, or other lesions that may contribute to incontinence.^{10,12} In uncircumcised males, the foreskin should be examined to rule out phimosis or poor hygiene.

Bladder function information can be obtained by a provocative stress test, measurements of voided volumes, and estima-

tion of post-void residual. A provocative stress test can be completed by having the patient cough (with a full bladder) and noting any urine leakage.⁹ Specimen containers that fit on the toilet seat provide an easy method of measuring voided volumes. A post-void residual should be assessed within 10 minutes of voiding or after an incontinent event. Post-void residual can be estimated by physical exam (abdominal palpation, percussion, and pelvic exam). A post-void-residual urine volume determined by straight catheterization was considered a reliable measurement by some of the panel members who developed the AHCPR guidelines. The AHCPR guidelines define a post-void residual of 50 cc or less as adequate emptying and greater than 200 cc as inadequate emptying. (Clinical correlation with voided volume and other significant findings must be considered when evaluating the post-void residual amount, especially when volumes are greater than 50 cc and less than 200 cc.⁵)

Functional status should be evaluated by assessing the patient's mobility and dexterity to use the toilet. The need for assistive devices, such as a bedpan, commode, toilet, or urinal should also be determined.^{5,12,14}

Laboratory tests should include a urinalysis and culture to exclude urinary tract infection. Patients with glucosuria, proteinuria, inadequate bladder emptying, and voluminous urinary outputs may need blood studies such as glucose, urea nitrogen, creatinine, and calcium.⁹ Urine cytology may be indicated for patients with hematuria without infection.⁵ If it is difficult to diagnose a clinical pattern or if treatment is unsuccessful, a simple cystometrogram (CMG) may be beneficial.⁹

Physical examination may reveal findings that would lead to consultation. Clinical situations in which referral is indicated are hematuria (in the absence of infection), recurrent symptomatic urinary tract infection, difficulty with bladder emptying, severe prolapse with symptoms, prostate nodule, or new neurological pathology.^{5,14}

Treating incontinence

The AHCPR guidelines for incontinence in adults state that the least invasive and least dangerous interventions should be the first treatment choice.⁵ Because many residents of long-term care facilities are of advanced age, are frail, or have concomitant diseases or conditions, surgical or pharmacological options for incontinence treatment may be contraindicated. However, there is encouraging evidence that noninvasive behavioral interventions are effective in incontinence treatment. Several behavioral interventions have been used in the long-term care setting, including habit training or timed voiding, bladder training or retraining, and prompted voiding.

Habit training, which is most effective in cognitively impaired individuals with impaired mobility and urge incontinence, involves a fixed voiding schedule to keep the person dry.

Schedule adjustments are based on patterns of continent and incontinent voidings as identified in the bladder record. This approach is frequently used in long-term care facilities, has no known side effects, and effectively reduces incontinent episodes in cognitively impaired individuals. However, this intervention does not promote self-toileting efforts and is highly dependent on nursing staff compliance.

Bladder retraining is most appropriate for individuals who are able to discern bodily sensations and who are motivated to follow a schedule over several months. This technique requires keeping a bladder record to identify elimination patterns. An individualized schedule for using the toilet is then established, and the patient is taught to progressively delay the use of the toilet through various relaxation and other tactics. The objective is to achieve a normal pattern of urination. Sometimes, bladder retraining is used in conjunction with pharmacological agents. This approach involves active patient participation and has no known side effects, except those associated with adjuvant medications. It is most effective in treating bladder instability and in some cases of stress incontinence.

Prompted voiding has been effectively used with cognitively and physically impaired nursing home residents who have a maximum voided volume above 200 cc, who have a baseline voiding frequency of less than four times in a 12-hour period, who are able to respond initially to prompting, and who have a post-void residual less than 100 cc.¹⁷ This approach involves three major components: monitoring, prompting, and praising of the individual.⁵ The goals are to increase an individual's ability to discern his or her continence status and initiate requests for access and assistance to the toilet. Staff check the patient for continence status on a regular schedule, prompt the patient to use the toilet, and praise the patient if he or she is dry and uses the toilet appropriately. As with habit training, staff compliance to the schedule is crucial to the success of this approach. Physician and administrative feedback to staff about their performance in monitoring, prompting, and praising the individual's continence status appear to be crucial to this intervention's success in the long-term care setting.

The AHCPR guidelines also address pharmacological agents appropriate for the specific type of incontinence.⁵ Because urge incontinence is prevalent in the elderly population, an anticholinergic may enhance a bladder training program in patients with no contraindications. Assessment findings must be considered when adding a medication.

Other management techniques

Due to serious complications from long-term use, an indwelling bladder catheter should not be used except during an acute illness, when an accurate measure of intake and output are needed, or for the comfort of terminally ill individuals.

Intermittent catheterization may be an appropriate alternative if regular bladder drainage is needed.

Absorbent and disposable products are widely available and may be appropriate for a limited time (e.g., when an incontinence intervention is initiated or for those who fail a therapeutic trial). However, pads and undergarments are expensive and may be demeaning for patients. Other products are effective in containing urine, such as condom catheters. These products should only be used in lieu of incontinence pads in the refractory patient since their use may interfere with the potentially ameliorating behavioral therapies. If these products are indicated, individual needs and preferences should be considered.

Summary

As health care providers, we should promote continence and the prevention of urinary incontinence. A comprehensive approach to assessment, therapy selection, and intervention evaluation is needed. Our challenge is to assure that urinary incontinence is not a fact of nursing home life.

References

1. International Continence Society. *The Standardization of Terminology of Lower Urinary Tract Function*. 1984.
2. National Institutes of Health. *Urinary Incontinence in Adults*. Bethesda, Maryland: US Department of Health and Human Services. 1988. (No. G291).
3. Mohide EA. The prevalence and scope of urinary incontinence. *Clin Geriatr Med*, 1986; 2:639–55.
4. Burgio LD, Jones LT, Engel BT. Studying incontinence in an urban nursing home. *Journal of Gerontological Nursing*, 1988; 14(4):40–45.
5. Agency for Health Care Policy and Research. *Urinary Incontinence in Adults: Clinical Practice Guidelines*. Rockville, Maryland. Department of Health and Human Services. 1992. AHCPR Pub. No. 92–0038.
6. Staskin DR. Age-related physiologic and pathologic changes affecting lower urinary tract function. *Clin Geriatr Med* 1986; 2(4):701–710.
7. Schnelle JF, Traughber B, Morgan DB, Embry JE, Binion AF, Coleman A. Management of geriatric incontinence in nursing homes. *J Appl Behav Anal*, 1983; 16:235–41.
8. Kane RL, Ouslander JG, Abrass IB. *Essentials of Clinical Geriatrics*. New York: McGraw Hill. 1984.
9. Ouslander J, Staskin D, Orzeck S, Blaustein J, Ray S. Diagnostic tests for geriatric incontinence. *World Journal of Urology*. 1986; 4:16–21.
10. Resnick N. Urinary incontinence in the elderly. *Medical Grand Rounds*. 1984; 3(3):281–90.
11. Resnick N, Yalla S. Management of urinary incontinence in the elderly. *N Engl J Med* 1985; 313(13):800–4.
12. Orzeck S, Ouslander JG. Primary incontinence: an overview of causes and treatment. *Journal of Enterostomal Therapy* 1987; 14:20–27.
13. Resnick NM, Yalla SV. Detrusor hyperactivity with contractile function. *JAMA* 1987; 257:3076–81.
14. Ouslander JG. Urinary incontinence: geriatric challenge. *Diagnosis* 1988; 10:42–52.

15. Blaivas JG, Raz S, Resnick NM, Whelan J. When the problem is incontinence. *Patient Care* 1988; 1:69-98.
16. DuBeau CE, Resnick NM. Evaluation of the cause and severity of geriatric incontinence. *Urol Clin North Am* 1991; 18:243-56.
17. Schnelle J. Treatment of urinary incontinence in nursing home patients by prompted voiding. *J Am Geriatr Soc* 1990; 38:356-60.

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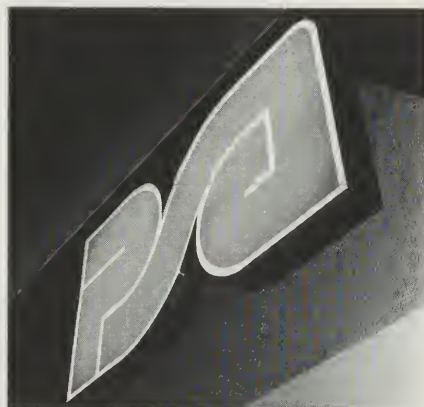
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DIAGNOSIS: Paget's Disease

The conventional radiograph (figure 1) demonstrates a focal osteolytic lesion (arrows), involving the proximal humerus. The nuclear medicine bone scan (figure 2) reveals markedly increased radiotracer uptake (arrow), at this site. The x-ray and nuclear findings are non-specific; the differential diagnosis includes aggressive processes such as metastatic neoplasm. The MRI scan (figure 3) demonstrates no evidence of marrow infiltration (dark marrow) to suggest tumor or infection. Simply, a focal distortion of the trabecular pattern with preservation of bright marrow fat (arrows), characteristic of Paget's disease is observed.

MRI is extremely sensitive to marrow infiltrating diseases such as primary and metastatic neoplasm, blood dyscrasia, lymphoma, infection and myelofibrosis. Normal marrow fat, which appears bright on T1 weighted images, is replaced by dark signal intensity, providing excellent contrast between normal and abnormal marrow. In this case, no such marrow infiltration or replacement is observed. The pattern of fat preservation with trabecular distortion is the typical MRI appearance of Paget's disease. The x-ray and nuclear medicine findings are much less specific but are also consistent with this diagnosis.



FIGURE 1



FIGURE 2



FIGURE 3

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The restraint-free approach to behavior problems in the nursing home

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ABSTRACT: *The Omnibus Budget Reconciliation Act of 1987 states that nursing home residents have the right to be free of physical and chemical restraints that are not required to treat the residents' medical symptoms. The article outlines a "restraint proper" approach to treating behavior problems: assess the problem, establish a presumptive diagnosis, consider the risks and benefits of treatment alternatives, select the best treatment for the individual patient, evaluate the effectiveness of treatment and side effects, change treatment as necessary, discontinue treatments when they are no longer needed, and provide documentation.]*

On October 1, 1991, the regulations implementing the portions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) that apply to nursing home care went into effect. These regulations state that "The resident has the right to be free from any restraints imposed; or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."¹ It is no longer acceptable to order that a patient who repeatedly falls be restrained in a chair or to order sedation for a patient who calls out and disrupts his or her roommate. The regulation does not preclude ever using these approaches but restricts their use to those situations in which they are "required" for the patient's treatment. The label "restraint free" is an overstatement; we are required to use a "restraint proper" approach.

A growing literature has questioned the use of physical restraints.² There is little evidence to support the assumption that physical restraints prevent injuries; indeed, some patients are clearly harmed by physical restraints. In England and Scandinavia, elderly patients in long-term care facilities are generally treated without these devices.

Some commentators have thought that the regulations regarding psychotropics go too far and are unnecessary, but our use of psychotropic drugs as

chemical restraints does not stand up to careful analysis. Lantz et al.³ found that over a five-year period, 70% of nursing home residents received psychotropics at some point. Garrard et al.⁴ found that for 50% of those residents receiving antipsychotic agents, there was not documentation of a condition justifying the use of these agents. Even where there was documentation in the patient's record that the choice of a psychotropic agent and the dose was appropriate for the diagnosis and condition of the patient, Johnson et al.⁵ were unable to find evidence that the therapeutic effects or the side-effects of treatment were monitored.

What do the regulations require of the attending physician? If one steps back from a word-by-word analysis, it becomes clear that we are being asked to treat behavior problems in the nursing home with the same rigor and scientific approach that we apply to medical conditions such as hypertension or diabetes.

The medical approach to behavior problems

Jenike^{6,7} described the basic approach to follow when using psychotropic agents with the elderly. With little effort, we can expand it to include all approaches to dealing with behavior problems in the nursing home.

Assess the problem. What is the behavior we are being asked to treat? Is it really a problem or simply a misunderstanding? (For example, nursing home patients with dementia or other organic brain conditions may show confusion or agitation in the evening. This pattern is commonly called "sundowning," although it may have little to do with the change in light levels. Thus, the question may be is the patient sundowning, or has the facility decided that residents should not watch television after 8 p.m.?) How often and when does the behavior occur? Is there a history of such difficulty in the past? Are there any inciting or contributing causes?

Establish a presumptive diagnosis. Since we know that frail elderly patients may present with a change in behavior due to many causes, including an exacerbation or acute onset of illness, medication toxicity, or emotional upheaval, a careful evaluation is necessary. Depending on the situation, this may include interviews with the patient, family, and staff; physical examination of the patient; and review of medications, treatments, and laboratory tests. As physicians, we regularly see patients who experience a fall and, on examination, are found to have pneumonia, a urinary tract infection, or an arrhythmia. Some patients may be agitated due to pain, incontinence, or loneliness. A new medication may have been added to the regimen or a dose changed with the side effects expressed as confusion, which may lead to a behavior problem.

Consider the risks and benefits of treatment alternatives. Nursing staff and physical and occupational therapists are learning a wide range of generally simple and inexpensive approaches to caring for patients whom physicians have traditionally restrained. Examples of these approaches include

wedge cushions, bolsters, and tilting-back chairs for those who cannot maintain their posture in a chair; alarms for those who try to get out of bed or a chair without assistance; and visual barriers such as a two-inch-wide Velcro strap across a doorway to stop wanderers. As compared with safety belts and vests, these alternatives do not increase patients' risk of strangulation, affect muscular decompensation, or contribute to increased agitation or loss of dignity. And, when used appropriately, they can prevent dangerous behaviors.

For behaviors occurring in patients with dementia or psychiatric disease, there are a range of environmental and human interventions that may effectively substitute for psychotropics. For example, pain can be relieved with nonnarcotic analgesics, physical activity can be increased to redirect agitation or wandering, and offensive environmental factors, such as noise or overcrowded conditions, can be addressed and controlled. Behavior management techniques may be effective even in those with some degree of dementia. The best clues as to which behavior management techniques would be most appropriate are likely to come from the nursing staff who are in daily contact with the patient or from the family.

Select the best treatment for the individual patient. There is no cookbook of treatments. The entire care team should be involved in matching the intervention to the characteristics and needs of the individual patient. If a decision is made to use a psychotropic agent, it should be chosen after reviewing the other medications the patient receives and after examining the side-effect profile for the drug. For example, giving a highly anticholinergic antipsychotic to a patient with persistent constipation will sometimes produce a large bowel obstruction, and benzodiazepines frequently cause increased confusion in patients with dementia. Nonpharmacological interventions must be individualized (e.g., a bolster may be appropriate for some patients, while a wedge cushion will work better for others).

Evaluate the effectiveness of treatment and side effects. When we start a newly hypertensive patient on medications, we will routinely monitor blood pressure and look for side effects. The same approach is necessary when treating behavior problems. We need to monitor specific behaviors and document any changes in severity or frequency to substantiate the treatment's effectiveness and justify its continued use.

If we are using nonpharmacologic interventions, there is generally little concern regarding side effects, although the patient who used to fall regularly but whose gait is now steady may become a wanderer. Concern about side effects of psychiatric agents is much greater. Lethargy and confusion are common with almost all these agents. Antipsychotics and some antidepressants are associated with extrapyramidal effects. Tardive dyskinesia is the most common of these effects in the frail elderly and may occur with the first dose of a drug or after treatment with very low doses. In my experience, nursing home patients generally do not complain of these effects, but the effects are upsetting to families. Under OBRA 87 regulations,

nursing facilities are required to monitor patients for tardive dyskinesia on initiation of antipsychotic drug use and at least every six months while the drug is being used. Many facilities use the Abnormal Involuntary Movement Scale (AIMS) for this purpose.

Change treatment as necessary. If the problem is complex or an effective intervention is not found, physicians should not hesitate to request appropriate consultation just as they would for a difficult cardiac or endocrinologic problem. Failure to find an effective nonrestraining treatment does not justify the use of restraints unless the situation meets the requirements of the regulations.

Discontinue treatments when they are no longer needed. The same considerations should be given to tapering or discontinuing treatment whether it is medication or nonpharmacologic treatment. The most common error is to continue the dose of a psychotropic drug when it is no longer needed. Behavior problems tend to come and go, even without intervention.

Documentation. To minimize liability and to assure appropriate patient care, each step described in the previous section should be carefully documented. Documenting assessment findings, presumptive diagnoses, the treatment goal in terms of the problem behavior, and effectiveness of the intervention is necessary.

Summary

Minimizing physical and chemical restraints seems to have clear benefits for many patients. In the author's experience, minimizing restraints has not required an increase in costs or staffing, although it does demand more of the nursing staff. Many effective interventions have been identified by the nursing assistants who provide daily care to a patient. Staff pride in the job increases when their recommendations are used, and patients benefit from better care.

References

1. Health Care Financing Administration. Medicare and Medicaid: requirements for long-term care facilities. *Federal Register* 1989; 54:5316-36.
2. Evans L, Strumpf N. Tying down the elderly: a review of the literature on physical restraint. *J Am Geriatr Soc* 1989; 37:65-74.
3. Lantz M, Louis A, Lowenstein G, Kennedy G. A longitudinal study of psychotropic prescriptions in a teaching nursing home. *Am J Psychiatr* 1990; 147(12):1637-39.
4. Garrard J, Makris L, Dunham T. Evaluation of neuroleptic drug use by nursing home elderly under proposed Medicare and Medicaid regulations. *JAMA* 1991; 265:463-67.
5. Johnson JF, DiBona JR. A concurrent quality assurance review of psychotropic prescribing in elderly patients: process and outcome measures. *Journal of Geriatric Drug Therapy* 1990; 4(4):43-80.
6. Jenike MA. *Handbook of Geriatric Psychopharmacology*. Chicago, Illinois: Year Book Medical Publishers, Inc. 1985.
7. Jenike MA. *Geriatric Psychiatry and Psychopharmacology: A Clinical Approach*. Chicago: Year Book Medical Publishers, Inc. 1989. ■

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Fever in the nursing home resident

Jennifer M. Lindsay P.A.-C., M.L.A.; William B. Greenough III, M.D.;
Lori B. Zelesnick, P.A.-C.; and Kris E. Kuhn, M.D.

At the time this research was conducted, Ms. Lindsay was a physician assistant at the [Johns Hopkins Geriatric Center]. Dr. Greenough is professor of medicine and of international health at Johns Hopkins University School of Hygiene and Public Health. Ms. Zelesnick is a physician assistant at the Johns Hopkins Geriatric Center. Dr. Kuhn is head of family practice at the University of Maryland.

ABSTRACT: *Body temperature is a convenient and objective indicator of the body's physiologic state. Typical and atypical febrile responses are discussed and their sources reviewed. Diagnosis, treatment, and prevention of fever in nursing home patients are highlighted.*

The ability to mount a febrile response is an important defense against infections, and this ability is associated with increased survival.^{1,2} Body temperature provides a convenient, easily measured, objective indicator of the body's physiologic state.³ In nursing home settings, we have found it helpful to define a fever as one or more degrees Fahrenheit above basal body temperature. Fevers, even low-grade fevers, may signal an important physiological change and should not be dismissed.

In this article, we will discuss typical and atypical febrile responses and review some of their noninfectious and infectious sources. Treatment of all fevers begins with assessing the environmental temperature and the hydration status of the patient. A nursing home resident's advance directive and established treatment goals are considered prior to conducting a comprehensive evaluation and initiating therapy. Specific interventions are based on physical and diagnostic observations and are directed at the probable cause of the fever. Ways to prevent fever due to infections, such as immunization against common pathogens and emphasis on universal precautions, will be briefly reviewed.

Establishing baseline body temperature and thermal responses

It is important to know the basal body temperature of each nursing home resident so that significant changes in body temperature can be recognized. Older people may have a lower mean temperature, and up to one-third of the elderly may not become febrile in situations that characteristically produce fevers in young adults. A blunted febrile response is even more likely in individuals over 75 years of age.¹ Thus, signs such as pallor, flushing,

shivering, mental status changes, or a drop in blood pressure may indicate an infection or drug reaction that might, in younger people, present as a fever. A nursing home resident with a low basal body temperature of 97° Fahrenheit who presents with a temperature of 100° F is of greater concern than a resident with a basal body temperature of 99° F who presents with a temperature of 100° F.

In evaluating temperature changes in the elderly, both blunted and magnified thermal responses should be considered. Altered responses may occur for a variety of reasons. Individuals who are older and chronically ill may be less efficient in thermoregulation. Diminished responsiveness of the cardiovascular system or a diminished ability to sweat may occur in the elderly and the chronically ill. There may be a loss of sensitivity by the hypothalamic center (which controls body temperature) that will alter thermal responses in the nursing home resident.⁴ Disease or age-associated changes in cellular and humoral immune systems can also alter febrile responses.

In addition, many elderly patients are less able to generate heat due to decreased muscle mass and compromised mobility. Other factors, such as strokes or other neurologic diseases, hyperthyroidism, and diabetes, can increase febrile responses. Medications, such as phenothiazines, anticholinergics, diuretics, beta blockers, nonsteroidal anti-inflammatory agents, neuroleptic drugs, sedatives, tranquilizers, and alcohol can amplify a hyperthermic response.^{1,4}

Fevers may be due to environmental conditions such as high ambient temperature, high humidity, layers of clothing or blankets, or direct sunlight. These factors may have a greater impact on the elderly nursing home resident than traditionally recognized. Nursing home residents live in a closed environment where many are unable to control their institutional climatic conditions by removing or adding clothes or blankets. The residents may not be able to obtain food or water or regulate their activities. When elderly residents are overheated, overclothed, or underhydrated, fever can result.

Causes of fever

Many residents, as a result of illness or disability, are incontinent, and their ability to communicate needs or symptoms is compromised, which compounds the external influences on thermal regulation. This dependent population is exposed to all the communicable infections that medical staff, three shifts of nursing staff, and visitors can carry. The nursing home is a special microbial environment where previous or frequent antibiotic use leads to resistant bacteria such as methicillin or aminoglycoside-resistant *Staphylococcus aureus*, or to overgrowth pathology such as *Clostridium difficile*.

In Finnegan's 12-month surveillance of fevers in a long-stay institution, fevers of unknown cause were noted in 35% of the 114 instances.⁵ Such fevers are more likely to be one to three days in duration, and they resolve with symptomatic interven-

tions. (We are not referring to the classic definition of fevers of unknown origin of three weeks' duration.) Dehydration and atelectasis are two probable common sources of noninfectious fevers in the nursing home resident. Unfortunately, little research has been done to identify the noninfectious sources of fevers in nursing homes when there is no clear infective agent present.

Infections. Fevers secondary to infectious agents occur 1.5 million times a year in American nursing homes. Bacterial infections in nursing homes occur more often in nursing home residents who have been admitted within the previous 45 days, are older than 74 years of age, and have an indwelling Foley catheter. Bacterial infections are also more common in residents who have an average of 3.3 or more chronic illnesses.^{5,6} Respiratory and urinary tract infections are the two most common infections in nursing homes. Infectious diseases, according to a study by Mott and Baker, were responsible for 54% of all medical-surgical problems, 48% of hospitalizations, and 63% of deaths in the nursing home studied.⁷

Bacterial and viral infections tend to be seasonal and to occur in clusters. Pneumonia, influenza, and diarrheal diseases occur predominately in the winter months, while cellulitis presents more often in the summer months. Consulting the nursing staff and the infection control nurse can provide the clinician with prompt information concerning an outbreak of influenza, pneumonia, diarrhea, or cellulitis in a nursing home. Notifying the infection control nurse of a patient diagnosed with a communicable disease is an important early action for which the clinician is responsible. Prompt communication about a transmissible disease is essential to assure proper infection control management within a nursing home.

Urinary tract infections. Patients with fevers due to urinary tract infections present in a variety of ways. Bacteriuria with dysuria, increased urinary frequency, and flank pain are often not present in the elderly, while nonspecific changes in attention and activity or fever without another explanation may indicate a urinary tract infection. There is an increased risk of urinary tract infection with indwelling Foley catheters, and gram negative sepsis is more likely to occur after manipulation of a Foley catheter.

Institutions and specialized areas within institutions tend to have changing patterns of specific pathogens and antibiotic resistance. Many different organisms are responsible for urinary tract infections; therefore, cultures are important to adequately identify the correct organism and to test for antibiotic susceptibility. However, the mere presence of more than 100,000 organisms in a patient's urine does not establish the urinary tract as the fever source since as many as 50% of women and 20% of men in nursing homes have bacteriuria.⁸⁻¹⁰ Thus, a nursing home resident who cannot communicate symptoms and who has fever and bacteriuria represents a difficult and ambiguous case.

Lower respiratory infections. Lower respiratory infections are typically a leading cause of bacterial fevers in nursing home residents. A resident's compromised swallowing reflex, and the nursing home's inability to provide aggressive pulmonary toilet predispose residents to pneumonia—a leading cause of death in the long-term care setting. The clinical presentation of lower respiratory infections can be varied but may include the sudden onset of shaking chills, fever, dyspnea, pleuritic pain, vomiting, and a cough. In the dehydrated resident, a cough may not be productive. Fever, increased respiratory rate, and a change in sputum production are hallmarks of an acute respiratory illness.

Gram stain and cultures are occasionally helpful in identifying causes of lower respiratory infections, especially in epidemic outbreaks and where antibiotic resistance is encountered. But gram stains and cultures of sputum are often difficult to obtain in nursing home residents, and organisms seen in the sputum do not necessarily correlate with the organisms that are infecting the lung.^{5,11}

Chest x-rays should be used selectively. Bronchial infections with fever and increased sputum production will not be seen on a chest film, yet these infections demand treatment in the elderly nursing home resident with obstructive lung disease. When there is a question about treating with an antibiotic, a chest x-ray and a wet reading may be helpful.

Diarrhea. Diarrhea in nursing home residents is often accompanied by fever, vomiting, and abdominal distention or pain. Diarrhea is common in nursing homes and is associated with an increase in mortality, particularly in the case of *C. difficile* infection. The etiologies of infectious diarrheal diseases in nursing home residents have not been studied with current diagnostic methods. The known etiologies of diarrhea include bacteria, viruses, and parasites. Fecal impaction and drugs such as colchicine, laxatives, and antibiotics are also associated with diarrhea. *C. difficile* is most likely the leading identifiable pathogen for diarrhea in the nursing home patient, but in the majority of instances, no pathogen is found. Stool cultures are helpful to rule out salmonellosis, but the potentially common sources of diarrhea, such as pathogenic enterotoxigenic *Escherichia coli*, are not recognized in most clinical laboratories.

Prompt fluid replacement with a properly constituted oral rehydration solution and oral treatment with 30 cc of bismuth subsalicylate every four hours as needed after each loose stool minimize the morbidity and mortality in patients with diarrhea. Correction of salt and water deficits is the first concern for patients who present with diarrhea, with or without fever.¹²⁻¹⁵

Skin infections. Comparison of prevalence studies conducted from 1980 to 1991 indicates that skin and pressure sore infections have fallen from the second to the fourth cause of fever in the nursing home patient. This decrease reflects

improved skin hygiene and an evolving understanding of pressure sore physiology, wound colonization, and the importance of nutrition for wound healing. Impetigo, boils, abscesses, and cellulitis are skin infections that can be associated with fever, malaise, anorexia, and headache.⁵⁻¹⁶ *Staphylococcus aureus* is the most common pathogen, but cultures are useful to positively identify the pathogen.

We have had a recent experience with an outbreak of *Group A Streptococcal* cellulitis in our chronic care hospital. The majority of cases presented with a rapidly spreading erythematous rash with ragged but well-defined borders and modest induration. Early identification by the nursing staff of the presenting rash allowed for penicillin therapy (intramuscularly or orally) to be initiated in a timely manner. Promptly identifying and treating the condition minimized the incidence of sepsis, hospitalization, and mortality.^{4,5,16}

Pressure ulcers are always colonized with bacteria and are rarely infected. Routinely assessing the pressure sore is important. When a wound has necrotic tissue, when the tissue color changes from red and healthy to pale and dull, when the wound's edges become red and inflamed, when the amount or color of the drainage changes or an odor is present, we become concerned about a wound infection. Surface swab cultures and tissue biopsy cultures are of value only when an aggressive pathogen, such as *S. aureus* or *Group A Streptococcus*, is suspected. Mixed aerobic gram-negative or anaerobic organisms, when responsible for wound infections, occur when there is inadequate debridement and inadequate local care. Prompt local wound care and nutritional and hydrational support can minimize the morbidity and mortality associated with bacteremia from pressure sores.¹⁷

Obscure fevers. A growing incidence of sepsis from multiple organisms has been noted.¹⁸ Patients with this condition appear ill and often present with fever and mental status changes. The source of the sepsis is often elusive, but previous intravenous injections, invasive procedures, indwelling foreign bodies, and gastrointestinal origins should be considered. Other fever sources to consider in the nursing home patient include drug-related fevers, collagen vascular disease, endocarditis, occult neoplasms, tuberculosis, human immunodeficiency virus (HIV) infections, and fungal infections.^{16,19}

Diagnosis

Evaluation of the febrile nursing home resident includes assessing activity and mental status. Does the resident look ill, or has there been a rapid decline in the patient's ability to move or in the patient's mental capabilities? Nursing home residents' complaints and symptoms can be vague and nonspecific. Often, residents may not be able to give any information. Physical assessment is the criterion used to determine treatment.

There is a fourfold greater probability of bacterial infection when a fever is present in an elderly person than when fever is not present. If a complete blood count is done, older persons with a bandemia and a normal white count are likely to have a bacterial infection. Residents with a fever (99.5°F), leukocytosis ($\geq 14,000/\text{mm}^3$), and a left shift (band % > 6) in a study by Wasserman had a bacterial infection 100% of the time.²⁰

Treatment

Hydration. An important accompaniment to, and possibly a precipitator of, fever is dehydration. Water constitutes 50% of the weight of an average young man and 60% of the average young woman, but the elderly have less water for their total body mass and a lower reserve to prevent dehydration. The clinical manifestations of dehydration are not striking unless substantial water loss has occurred. The usual signs, such as dry mucosa and poor skin turgor, are rarely helpful in identifying dehydration in the elderly. However, elevated temperature and tachycardia associated with a drop in blood pressure are signs of severe dehydration. An elevated blood urea nitrogen level (BUN) and creatinine level or evidence of hemoconcentration, such as increasing hematocrit or plasma protein levels, are helpful but may not be available. Dehydration treatment is based on the amount and composition of the estimated fluid loss (Table 1).

Dehydration secondary to decreased water intake is treated with water replacement in a palatable form. When fluid is depleted as a result of sweat loss, fluid is replaced with a sweat replacement solution of fluid and electrolytes such as Gatorade

or Exceed. When fluid loss is associated with renal failure, poor concentrating capacity, and salt loss, fluid is replaced with a sodium-containing solution without potassium. In our nursing home, we formulate a replacement solution by diluting 5% dextrose in a normal saline solution and combining with water (50/50). Fluid lost as a result of diarrhea is replaced with oral rehydration therapy (ORT) containing sodium, potassium, citrate, and glucose; this will facilitate reabsorption if the colon is inflamed. All these solutions are administered orally or through feeding tubes. The volume and speed of replacement are based on the rate of loss. In the elderly, impaired cardiac and renal function leave less margin for error. Proper hydration of the febrile patient is critical to successful management.

The patient's advanced directives and the goals of treatment must be considered with all interventions. The patient's comfort remains paramount, and interventions should reflect the patient's previously established treatment goals. The role of antipyretics has not been established in the elderly, but they are widely used for comfort. Bedside encouragement to drink when a patient refuses to have a nasogastric tube inserted for rehydration is time-consuming but often life-extending.

Antibiotics. Clinical assessment is required to decide whether it is safe to observe the febrile patient and hydrate while awaiting culture and sensitivity results to guide therapy. Clinicians are increasingly aware of the growing prevalence of antibiotic-resistant bacteria and the potentially fatal complications of post-antibiotic diarrhea. Antimicrobial therapy without appropriate diagnostic evaluation is frequently prescribed for the nursing home patient.^{5,6,19}

Table 1. Indicators and composition of oral or tube replacement solution in the elderly

| Condition | Type of solution | Composition | | | | |
|---------------------------------|------------------------|----------------------------|---------------------------|----------------------------|--|------------------|
| | | Na ⁺ (mEq/L) | K ⁺ (mEq/L) | Cl ⁻ (mEq/L) | HCO ₃ ⁻ (mEq/L) | Glucose (g/L) |
| Fever and increased respiration | Water | 0 | 0 | 0 | 0 | 0 |
| Heat and sweat | Cola | 0 | 0 | 0 | 0 | 50-100 |
| | Gatorade | 19.6 | 6.4 | 26.4* | | 60 ^b |
| Diarrhea | ORT (WHO) ^c | 90 | 20 | 80 | 30 | 20 |
| | Pedialyte | 45 | 20 | 35 | 30 | 25 |
| | Ricelyte ^d | 50 | 25 | 45 | 30 | 30+ |
| Renal failure | ORT ^e | 70 | 0 | 70 | 0 | 25 |

* chloride citrate

^b glucose and sucrose

^c bicarbonate usually replaced by citrate

^d rice syrup solids

^e potassium-free ORT must be made up specially, e.g., 5% dextrose saline mixture diluted 1:1 with water

ORT = oral rehydration therapy

WHO = World Health Organization

In clinical situations where antimicrobial therapy is thought necessary, it is important to act promptly. When antibiotic treatment is begun early, oral agents are often very effective. Thus, when a patient with chronic obstructive pulmonary disease has increased respiratory difficulty or change in sputum with or without fever, several antimicrobial regimens are suitable, including erythromycin, ampicillin or amoxicillin, trimethoprim with sulfamethoxazole, and an appropriate oxyquinolone. Selection of the oral agent for urinary tract infections is best guided by the antimicrobial resistance patterns in a particular institution. It is often more important to know the characteristic resistance pattern than the taxonomic classification of a particular organism.

The presence of bacteria in the urine is not enough to warrant treating an elderly patient for a urinary tract infection (UTI). UTI is distinguished from asymptomatic bacteria in the elderly by the presence of symptoms and moderate to large pyuria. Spontaneous clearance or antibiotic eradication of bacteriuria in the elderly nursing home patient is uncommon.^{6,8,18,19}

When a patient appears to have bacteremia with chills, fever, and hypotension, intramuscular antibiotics such as penicillin, ceftriaxone, or piperacillin can be initiated promptly, especially when there may be a delay in hospitalization or the patient does not wish to be hospitalized for intravenous therapy.²¹⁻²³

The nature and prevalence of the particular infections common to a nursing home should be monitored and therapy adjusted based on such knowledge. Infectious disease patterns in nursing homes vary seasonally and by region. Infection control monitoring data should be considered in prescribing antibiotic therapy for infections in nursing home patients.

A special comment is needed on the recognition and treatment of diarrhea. There are no indications to use antimicrobial therapy in diarrheal disease in the nursing home except when *C. difficile* is suspected. Although metronidazole may be effective in such an instance, vancomycin remains the drug of choice if there is fever, distention, and abdominal pain.²⁴

Prevention

Preventing infections in nursing home patients begins with PPD (purified protein derivative) testing on admission and a recent chest x-ray. Upon entry to the facility, Pneumovax (pneumococcal vaccine polyvalent) should be used to prevent pneumococcal pneumonia. Influenza vaccine should be administered to all nursing home residents and employees every November, and nutritional and hydration practices should be aggressively reinforced. Strict adherence to universal precautions, especially hand washing by nurses, medical staff, and visitors, is an inexpensive yet effective means of preventing the spread of infections in nursing homes.

Conclusion

A fever, defined in this article as one degree Fahrenheit above a patient's basal body temperature, is a physiologic response to external, environmental, or physiologic demands and to infections. In nursing home patients, a febrile response may be altered by conditions of aging, chronic illness, environmental factors, or drug therapy. Managing a febrile episode requires a systematic approach that begins with the nursing home environment and careful patient evaluation. The patient's advance directives and established treatment goals should guide interventions. Prompt environmental and clinical assessment, hydration, and, when appropriate, antibiotic therapy are key to successful fever management in nursing home patients.

References

1. Castle SC, Norman DC, Yeh M, Miller D, Yoshikawa TT. Fever response in the elderly nursing home resident: are the older truly colder? *J Am Geriatr Soc*, 1991; 39:853-57.
2. Kluger MH, Ringer DH, Anver MR. Fever and survival. *Science* 1975; 18:166-168.
3. *Harrison Principles of Internal Medicine*. 11th ed. New York: McGraw Hill. 1987. pp. 50-53.
4. Robbins AS. Hypothermia and heat stroke: protecting the elderly patient. *Geriatrics* 1989; 44:73-80.
5. Finnegan TP, Austin TW, Cape RD. A 12-month fever surveillance in a veterans' long-stay institution. *J Am Geriatr Soc* 1985; 33:590.
6. Smith PW. Nursing-home-acquired infections. what to do about control and treatment. *Postgrad Med* 1987; 81(6):55-65.
7. Mott PD, Baker WH. Treatment decisions for infections occurring in nursing home residents. *J Am Geriatr Soc* 1988; 36:820-24.
8. Denman SJ. Urinary tract infections in the nursing home. *Clinical Report on Aging* 1989; 3(1):1-5.
9. Catheter-acquired urinary tract infection. *Lancet* 1991; 338:857.
10. Turck M, Stamm W. Nosocomial infection of the urinary tract. *Am J Med* 1981; 70:651-54.
11. Verhese A, Berk SL. Bacterial pneumonia in the elderly. *Clinical Report on Aging* 1989; 3(2):1-5.
12. Bender BS, Bennett R, Laughon BE, et al. Is *Clostridium difficile* endemic in chronic-care facilities? *Lancet* 1986; 2(8497):11-13.
13. Choi M, Yoshikawa TT, Bridge J, Schlaifer A, Osterweil D. Salmonella outbreak in a nursing home. *J Am Geriatr Soc* 1990; 38:531-34.
14. McFarland LV, Stamm WE. Review of *Clostridium difficile*-associated disease. *Am J Infect Control* 1986; 14:99-109.
15. Diarrhea - etiology and treatment with oral rehydration therapy. *Senior Medical Reviews* 1988; 2(3):1-8.
16. Garibaldi RA, Brodine S, Matsumiya S. Infections among patients in nursing homes: policies, prevalence and problems. *N Engl J Med* 1981; 305:731-35.
17. Krasner D. Chronic Wound Care—A Clinical Source Book for Health Care Professionals. King of Prussia, Pennsylvania: Health Management Publication, Inc. 1990.
18. Liebovici L, Konisberger H, Pitlik S, Samra Z, Drucker M. Bacteremia and fungemia of unknown origin in adults. *J Clin Infect Dis* 1992; 14:436-43.

19. Warren JW, Palumbo FB, Fitterman L, Speedie SM. Incidence and characteristics of antibiotic use in aged nursing home patients. *J Am Geriatr Soc* 1991; 39:963-72.
20. Wasserman M, Levinstein M, Keller E, Lee S, Yoshikawa TT. Utility of fever, white blood cells and differential count in predicting infections in the elderly. *J Am Geriatr Soc* 1989; 37:537-43.
21. Brown NK, Thompson DJ. Nontreatment of fever in extended-care facilities. *N Engl J Med* 1979; 300:1246-50.
22. Fabiszewski KJ, Volicer B, Volicer L. Effect of antibiotic treatment on outcome of fevers in institutionalized Alzheimer patients. *JAMA* 1990; 263:3168-72.
23. Yoshikawa TT. Antimicrobial therapy for the elderly patient. *J Am Geriatr Soc* 1990; 38:1353-72.
24. Bennett RG, Greenough WB III. Diarrhea: a ubiquitous disease in older persons. *Clinical Report on Aging* 1987; 1:1-9.
25. Katz PR, Beam TR. Infections in the nursing home. *Clinical Report on Aging* 1989; 3:(4):1-5.
26. Standfast SJ, Michelsen PB, Baltch AL, Smith RP, Latham EK, et al. A prevalence survey of infections in a combined acute and long-term care hospital. *Infection Control* 1984; 5(4):177-84.

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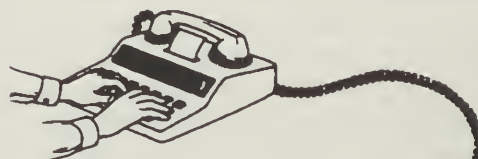
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The wound unit: a specialized unit for pressure sore management in a long-term care facility

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ABSTRACT: *Approximately 20% of all patients admitted to long-term care facilities arrive with pressure sores. An additional 12% develop new sores over each subsequent six-month period. Management of pressure sores has traditionally been a time-consuming, inefficient, and costly exercise. We describe the efforts to standardize and improve the care of patients with pressure sores at a 360-bed chronic care and nursing facility in Maryland. The efforts began with a pressure ulcer team, and continued with the establishment of a wound protocol and, ultimately, a wound unit.*

The optimal management of pressure sores is a growing concern for health care facilities. Although most pressure sores (57%–66%) are acquired in the acute care setting,¹ hospitals are ill-suited to provide the extended care needed by these patients because of cost-containment constraints. Thus, the burden of caring for patients with pressure sores has shifted to the long-term care sector.

Approximately 20% of all nursing home admissions arrive with pressure sores.² An additional 12% of the longer-stay residents develop new onset pressure sores over each subsequent six-month period,³ and 25% of nursing home residents with at least one pressure sore develop a new sore within six months.⁴ About 15 to 30 minutes of additional nursing staff time per patient is needed to apply each pressure sore treatment and document it in the medical record.⁴ Therefore, it is incumbent upon nursing homes to improve pressure sore management to enhance patient outcomes and maximize staff efficiency.

We describe efforts to standardize and improve the care of patients with pressure sores at the Deaton Specialty Hospital and Home, a 360-bed chronic care and nursing facility in Baltimore, Maryland. These efforts began with a pressure ulcer team, and continued with the establishment of a wound protocol and, ultimately, a wound unit.

Table 1. Pressure sore treatment

| Characteristics | Type | | | | | | | |
|---|-----------------------|-------------------------------------|-------------------------------------|-------------------------------------|---------------------------------|---------------------|----------------------|---------|
| | Stage I | Stage II | | Stages III & IV | | | Skin tears | Eschar |
| | | A. Hip girdle | B. Extremities | A. No odor | B. Mal-odor | C. Undermining | | |
| ◆ Nonblanching erythema ◆ Skin intact ◆ Hip girdle | Transparent dressing | | | | | | | |
| ◆ Nonblanching erythema ◆ Skin intact ◆ Extremities | Hydrocolloid dressing | | | | | | | |
| ◆ Full granulation ◆ Minimal or no drainage | | Transparent dressing | Hydrocolloid dressing | Normal saline wet-to-moist dressing | Medicated wet-to-moist dressing | Absorptive dressing | Transparent dressing | |
| ◆ < 50% adherent fibrous necrotic surface ◆ Minimal drainage | | Normal saline wet-to-moist dressing | Normal saline wet-to-moist dressing | Normal saline wet-to-moist dressing | Medicated wet-to-moist dressing | | | |
| ◆ < 50% adherent fibrous necrosis ◆ Moderate to large amount of drainage | | Normal saline wet-to-moist dressing | Normal saline wet-to-moist dressing | Normal saline wet-to-moist dressing | Medicated wet-to-moist dressing | Absorptive dressing | | |
| ◆ > 50% necrosis | | Surgeon | Surgeon | Surgeon | Surgeon | Surgeon | | Surgeon |

Problems in managing pressure sores

We found the following limitations to cost-efficient and effective care of patients with pressure sores at our institution:

- ◆ Problems in recognition and proper staging of pressure sores
- ◆ Inefficient use of nursing staff due to variable treatment regimens
- ◆ Variable treatment implementation
- ◆ Increased demands on staff time
- ◆ Inappropriate use of surgical interventions
- ◆ Inadequate treatment of malnutrition
- ◆ Poor control of infectious diseases
- ◆ Pairing of patients with differing goals and expectations
- ◆ Low staff morale

Each of these concerns must be addressed to successfully manage patients with pressure sores.

Recognizing patients at risk and appropriately documenting impaired skin integrity have important implications for patients and the facility. Identifying patients prone to pressure sores at the time of admission can prompt the use of preventive measures that may reduce the incidence of dermal breakdown. Proper staging of pressure sores is needed to ensure the appropriate level of nursing care and to monitor therapeutic progress.

The panoply of therapies for treatment sores can lead to significant problems. First, nursing efficiency is hampered by the need to gather the various treatment supplies at each dressing change. Second, consistency of care is difficult to assure as nurses may interpret instructions individually. Third, the increased time nurses spend treating pressure sores takes them away from other nursing functions and impinges on the availability of nurses to provide other kinds of comfort care.

The pressure ulcer team

To address these problems, Deaton established a pressure ulcer team in 1975 composed of a nurse specialist and two licensed practical nurses.⁴ The team examined all admissions with pressure sores to assure that every wound was identified, characterized according to a uniform staging system, and documented in the medical record. Once the attending physician defined the treatment regimen, the team assumed the daily management and monitoring of all clinically significant pressure sores.

This approach improved efficiency and quality of care throughout the institution. The team established protocols for each type of ulcer and was responsible for all treatments. This made it easier to maintain an adequate supply of treatment products and increased the consistency with which the regimens were implemented. The nurse specialist performed simple debridements, allowing for more timely interven-

Table 2. Admissions and discharges to the wound unit, Deaton Hospital, 1991

| # of admissions | Patients admitted | Patients discharged | Length of study (days) | | Discharge destination (%) | | | |
|-----------------|-------------------|---------------------|------------------------|---------------|---------------------------|--------|----------|------|
| | | | Patients discharged | All patients* | Other hospital | Deaton | Deceased | Home |
| 1 | 203 | 161 | 45.5 | 69.7 | 56.6 | 24.2 | 16.1 | 3.1 |
| 2 | 59 | 46 | 41.2 | 50.8 | 68.7 | 10.4 | 16.7 | 4.2 |
| 3 | 19 | 14 | 30.7 | 37.4 | 64.3 | 35.7 | | |
| 4 | 8 | 6 | 14.6 | 40.1 | 100.0 | | | |
| 5 | 1 | 0 | | 39.0 | | | | |

* December 31, 1991, was the end date used for calculating length of stay for patients who remained on the unit.

tions and less reliance on consultant surgeons. Wounds were measured at regular intervals to provide reliable data on which to base therapeutic decisions. These changes gave the nursing staff more time to attend to patients' other needs.

Despite these benefits, several problems persisted. First, the original protocols became dated, so physicians again developed individualized treatment plans. This reduced nursing efficiency again and increased costs because of the need to stock many infrequently used products. Second, physicians' time was not used efficiently: as the sores changed, treatment had to be changed, which necessitated a call to the attending physician for a new set of instructions. Third, the team dealt only with topical therapies. There was no consensus by medical staff as to management of pressure sores requiring other forms of treatment.

In 1990, the medical and nursing leadership convened a series of meetings to establish a standardized protocol for managing pressure sores, which was ultimately incorporated into the institution's policy.

Under the wound protocol, every patient admitted with a break in skin integrity is seen by the wound management team (formerly called the pressure ulcer team). Descriptions and staging of the pressure sores are based on procedures widely accepted in the literature. The protocol recommends a standardized set of laboratory tests at admission, including a complete blood count with differential, chemistry panel including electrolytes, blood urea nitrogen (BUN), creatinine, total protein, albumin, and a urinalysis. An anergy panel is optional, but all patients without contraindications receive PPD (purified protein derivative) testing. In addition, patients are assessed by a nutritionist and a physical therapist.

The wound protocol also includes updated management guidelines. A single treatment is recommended for each type of wound depending on location, stage, and characteristics (Table 1). Transparent dressings (thin, nonabsorbent, and

water-impermeable) allow full visualization of the wound and are also used as the covering of wet-to-moist dressings applied to deep wounds. Hydrocolloid dressings, which have limited absorbency, are more appropriate for lower extremity wounds where the surrounding skin is particularly susceptible to maceration. Absorptive dressings are used when the wound fluid cannot be contained by hydrocolloid dressings over a 24-hour period, which is a problem in wounds with undermined skin. The medicated wetting agents include dilute solutions of sodium oxychlorosene (Clorpactin), metronidazole, and amphotericin B.

The optimal therapy for each type of wound was determined by whether the treatment conformed to an accepted standard; which treatment was simplest and conserved nursing time; and which treatment products were available in less expensive generic formulations. In circumstances in which several alternative therapies might be useful, a limited number of options were approved. For a treatment regimen that is not listed, the attending physician must write a complete set of orders.

Standardizing the evaluation and treatment of pressure sores substantially improved medical management, but certain problems persisted. On the one hand, a physician could now write a single order that would cover nearly all contingencies and that would change as the patient's needs changed, and the physician would not have to be notified at each juncture. Should a complication arise, effective treatment options were available. Nursing efficiency improved, and the added responsibilities increased nurses' morale. The cost of treatment products was reduced because generic forms were used. On the other hand, patients with pressure sores were scattered throughout the facility, requiring the team to visit all the wards. Patients of different ages and cognitive status were paired, which sometimes upset more alert individuals. Research opportunities in pressure sore management finally stimulated the development of a single nursing unit for these patients.

The wound unit

The wound unit at the Deaton Specialty Hospital and Home includes all 64 beds on one floor of the facility. Wound unit nursing staff are under the direction of a single nurse manager and are divided into three teams. Teams evaluate each admission to the unit and develop a care plan according to the wound protocol. The teams implement and monitor the treatments, freeing other nursing staff to attend to patients' other health care needs. A fully equipped treatment room located on the unit facilitates patient access to surgical debridements.

We recently reviewed our experience on the wound unit for 1991—the first full year of operation (Table 2). A total of 203 patients, ranging in age from their early 20s to over 100, were admitted; 60.5% were female and 39.5% were male. Most patients had only one admission of slightly over two months' duration. Despite the admission requirement that a pressure sore extend through the dermis, approximately 25% of patients improved and were discharged to their home or transferred to a lower level of care within Deaton.

Multiple admissions were common, usually due to intercurrent acute illnesses. Patients in this group are presumed to have had a significant death rate: only 59 of 91 (65%) hospital discharges returned after the first admission and 19 of 32 (60%) after the second. However, others were transferred for more extensive surgical procedures, including myocutaneous flaps. They continued to improve and were discharged home or transferred to a lower level of care.

The wound unit has improved efficiency and the consistency of patient care:

- ◆ The teams have the majority of their cases in one location and are better able to coordinate dressing changes with other nursing activities.
- ◆ The specialized nature of the wound unit attracts nurses who wish to be a part of this effort; the heightened morale results in better patient care.
- ◆ The similarity of patients' needs improves the ability to assign appropriate staffing levels.
- ◆ A single nutritionist oversees diet orders, assuring a uniform approach and simplifying regimens.
- ◆ A single social worker has been assigned responsibility for the wound unit, which reinforces the sense of *esprit de corps* among the health professionals.

Congregating similar patients has led to efficiencies in bed use. There are fewer inappropriate pairings of patients. For example, young people with spinal cord injuries or patients in rehabilitation do not share a room with patients who have severe cognitive impairments or terminal illnesses; both the patients and their families are more satisfied. Infection control issues, such as isolating patients colonized with MRSA (methicillin-resistant *Staphylococcus aureus*), are more easily handled.

Clustering specialized beds also facilitates plant management. The heat generated by mechanized beds can make individual rooms uncomfortable. Clustering allows the environment of an entire unit to be regulated separately.

Specialized equipment, such as feeding and intravenous pumps, suction machines, and wheeled stretchers, are more likely to be used by this population. Since patients and equipment are in the same area, there is easier access to the equipment, and staff are more familiar with operating and maintaining it.

This organizational plan has also allowed the institution to identify a specialized market niche in pressure sore management that attracts patients and facilitates referral and admission procedures. A well-stocked treatment room equipped with appropriate lighting and a full complement of instruments for debridement has encouraged consulting specialists to offer in-house care. This saves transportation costs and lowers risks associated with hospital transfers.

The wound protocol and the wound unit have benefited the medical staff. The management of patients with pressure sores has been streamlined through these changes. Physicians who work at Deaton have greater recognition of the problem, appreciate the special facilities, and have increased their referrals to the unit. They have also used the protocol for their patients at other hospitals.

Future directions

Many questions in the treatment of patients with pressure sores remain unanswered. We hope the wound unit's experience will allow us to address some of these issues, including

- ◆ Consistency in describing sores, including volume and characteristics of sores as they evolve and heal
- ◆ More accurate measurement of wounds and the extent of involved tissue
- ◆ Improved healing of wounds using advanced technology
- ◆ Effects of contractures of the lower extremities on mobility and regional blood flow
- ◆ Use of growth factors to stimulate wound healing
- ◆ Use of new topical products to absorb wound secretions
- ◆ Nutritional interventions for optimal protein and calorie supplementation
- ◆ Evaluation of prognostic characteristics and outcomes for pressure sore management

Conclusions

Our systematic approach to pressure sore management required a facility-wide effort. Each step improved care by standardizing treatments and increasing staff efficiency. Patient care has benefited, and the institution has saved money while offering an important service.

References

1. Smith DM, Winsemius DK, Besdine RW. Pressure sores in the elderly: can this outcome be improved? *J Gen Intern Med* 1991; 6:81-93.
2. Spector WD, Kapp MC, Tucker RJ, Sternberg J. Factors associated with presence of decubitus ulcers at admission to nursing homes. *Gerontologist* 1988; 28:830-34.
3. Allman RM. Epidemiology of pressure sores in different populations. *Decubitus* 1989; 2:30-33.
4. Reed JW. Pressure ulcers in the elderly: prevention and treatment utilizing the team approach. *Md State Med J* 1981; 30:45-50. ■

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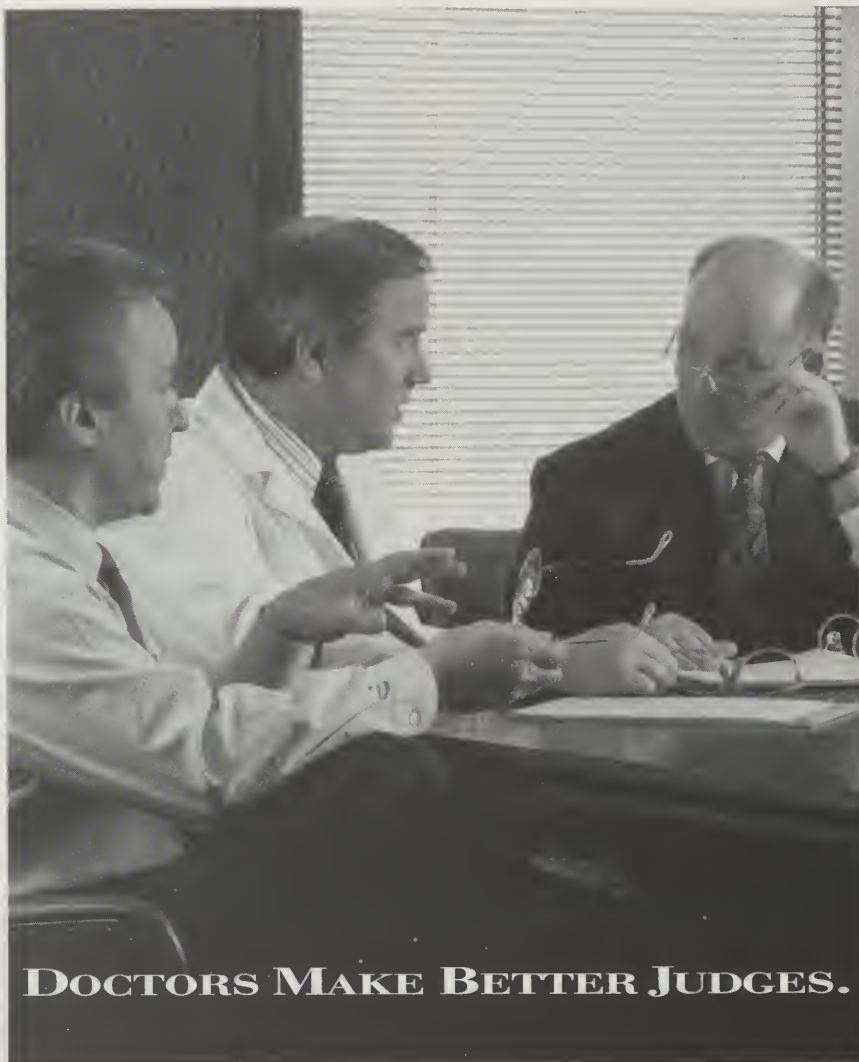
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Commentary

Summary of the NIH consensus statement on early identification of hearing impairment in infants and young children (1)

Approximately 1 of every 1,000 infants is born deaf. Many more children develop some degree of hearing impairment later in childhood. Any degree of hearing impairment during infancy and early childhood can have devastating effects on speech and language development, affecting learning and social and emotional growth. Furthermore, reduced ability to hear at a young age adversely affects the person's vocational and economic potential.

Despite the consequences of hearing impairment in infants and young children, the average age of identification in the United States is close to 3 years, well past the critical period for speech and language development. To evaluate current research and provide recommendations regarding hearing assessment from birth through 5 years of age, the National Institute of Deafness and Other Communication Disorders and the National Institutes of Health (NIH) Office of Medical Applications of Research sponsored a consensus development conference on the early identification of hearing impairment in infants and young children, March 1-3, 1993. Following one and a half days of presentations from experts in relevant fields and audience discussion, a 15-member nonfederal panel weighed the information and developed a consensus statement.

The consensus panel concluded that all infants should be screened for hearing impairment. The panel was able to make this recommendation since recent advances in technology have led to improved screening methods that provide the capability to identify hearing impairments in infants soon after birth.

Currently, the only infants screened are those identified with one or more high risk factors associated with hearing impairment, including low birth weight or a family

history of hearing impairment. These criteria, however, fail to identify 50% to 70% of children born with hearing impairments.

The screening procedure recommended by the panel would involve first screening the hearing of all infants with a test that measures otoacoustic emissions (OAEs). OAEs are low-intensity sounds produced by the inner ear that can be measured with a sensitive microphone placed in the ear canal. Measurement of OAEs was selected as the first test of the recommended screening procedure since it is a quick, inexpensive, accurate test of hearing sensitivity.

The panel further recommended that infants who fail the OAE screening have additional testing for auditory brain stem responses (ABR), which can confirm the validity of the OAE failure. Those infants who fail ABR should have a comprehensive hearing evaluation no later than 6 months of age.

Because infants admitted to neonatal intensive care units (NICU) have an increased risk of hearing impairment, the panel recommended that these infants' hearing should be screened just before discharge from the hospital. The panel also suggested that infants in the well-baby nursery with a family history of hearing impairment or diagnoses of craniofacial anomalies or intrauterine infections should have their hearing screened prior to discharge from the hospital.

Furthermore, the panel recommended that the hearing of all other infants be screened within the first 3 months of life, but added that this will be achieved most efficiently by screening prior to discharge from the well-baby nursery since the infants are more accessible for testing at that time.

However, the panel cautioned that 20% to 30% of hearing impairment in children occurs during infancy and

continued

Selecting the appropriate method and time for a hearing impairment screen: is the NIH consensus statement premature? (2)

Deafness is a serious handicap and significantly impedes normal development of infants and children. In a survey of 10-year-old children from five counties in Georgia, the Metropolitan Atlanta Developmental Study found that hearing impairment was the third ranking cause of disability with an incidence of 1 per 1,000 children studied.¹

Studies such as this emphasize the significant role that a lack of hearing can play in adversely affecting a child's future.

Concern generated by this problem led to a conference on early identification of hearing impairment in infants and young children sponsored by the National Institutes of Health (NIH), which was attended by recognized authorities from appropriate

early childhood. Therefore, the panel strongly urged that hearing screening be continued at intervals throughout early childhood. Parental concern should be elicited during well-baby visits to physicians, and speech and language development should be evaluated during those visits using formal assessment tools. Failure to reach appropriate language milestones should result in prompt referral for hearing evaluation. Parental concern expressed about the hearing of their child should be sufficient reason to initiate prompt formal hearing evaluation.

The panel also recommended that children recovering from bacterial meningitis as well as those with a history of significant head trauma, viral encephalitis or labyrinthitis, excessive noise exposure, exposure to ototoxic drugs, congenital-perinatal cytomegalovirus infection, familial hearing impairment, chronic lung disease, or diuretic therapy, and children with repeated episodes of otitis media with persistent middle ear effusion have their hearing tested. School entry screening at both public and

private schools should continue in order to provide another opportunity for universal identification of children with hearing impairments.

The panel urged future research to evaluate the validity and reliability of screening instruments and to compare various screening procedures for time and cost. The cost-effectiveness of universal screening for infant hearing impairment also needs to be investigated. The panel identified the need to develop innovative behavioral audiometry tests that are applicable for screening programs. Furthermore, the panel thought that large-scale studies should be conducted to evaluate the efficacy of early identification and intervention.

Free, single copies of the complete NIH Consensus Statement on the Early Identification of Hearing Impairment in Infants and Young Children may be obtained from the Office of Medical Applications of Research, National Institutes of Health, Federal Building, Room 618, Bethesda, Maryland 20892 (301-496-1143).

disciplines and which resulted in a consensus report.² A summary of the report is found above. The complete NIH report proposed and answered five key questions.

What are the advantages of identifying a hearing impairment early and the consequences of identifying a hearing impairment late?

The answers provided were fair and complete and emphasized the potential value of identifying infants with hearing impairments early. The type and degree of hearing disability, as well as the presence of other sensory or neurologic disabilities in a patient, influence the potential advantage of early identification. But, the sooner the problem can be identified, the sooner the problem can be evaluated and a corrective or remedial program begun.

Which children (birth through 5 years of age) should be screened for hearing impairment and when?

The NIH consensus report appropriately reviews all of the risk criteria that emanated as a position statement from the Joint Committee on Infant Hearing in 1982.³ Most important was the advice to be alert to parental concern. The report also advised screening all NICU (neonatal intensive care unit) babies, plus universal screening of all newborns within the first three months of life. The report further suggested that all newborns be screened prior to discharge from the nursery, even though the false positive rate of diagnosis may possibly be higher than if screening were done at a later time. Most certainly, the false positive rate would be higher. The members of the report's consensus panel also agreed that costs for well-baby nursery care would increase as a result of the screening.

They recommended that the screening procedure should be "rapid, reliable, highly sensitive, specific and easily administered by trained and supervised personnel." This is a critical issue of the report, addressed by the third and fourth key questions.

What are the advantages and disadvantages of current screening methods, and what is the preferred model for hearing screening and follow-up?

The report states that an ideal screening method—one that is available, inexpensive, specific and sensitive—does not exist. Of those methods available, the members of the consensus panel proposed that the evoked otoacoustic emissions (EOAE) test replace the auditory brain stem response (ABR) test for screening. Each test has its pros and cons. Each can be adversely affected by ambient noise, and both require trained personnel to administer them.

Proponents of EOAE testing argue that it requires less-skilled personnel, is less costly, and does not miss patients who would fail the ABR test. The EOAE proponents compare EOAE testing with standard ABR technology. But, many hospitals are using modified-ABR technology—an automated, computerized ABR technique (the ALGO-1 Infant Hearing Screen)—that has been found to be accurate, easy to administer, and less costly than standard ABR testing. Four studies in which ALGO-1 was used to screen newborns reported a specificity rate of 96% and a sensitivity rate of 98% when compared with results of conventional ABR testing.⁴ Trained volunteers can administer the EOAE and the ALGO-1, which would reduce costs. However, comparative studies between EOAE and ALGO-1 modalities have yet to be done.

Of great importance is that EOAE technology measures only peripheral hearing loss, and the validity of the test is compromised by obstructive material in the external auditory canal. It is hard to find an infant less than 24 hours of age who does not have debris in the external auditory canal; this, of course, can lead to a false positive result.

ALGO-1, however, measures both peripheral and brain stem auditory responses. The consensus statement considers the ABR the gold standard for evaluating hearing deficits and urges that infants failing EOAE be referred for ABR testing. It would appear that if ALGO-1 (a modified-ABR technique) fulfills the report's stated criteria of an ideal screening procedure more closely than other existing screening methods, it should perhaps become the preferred screening tool. Use of ALGO-1 could result in fewer false positive tests and reduce the number of patients referred for confirmatory testing. This would be a significant cost saving.

Appropriately, the report stresses that since hearing impairment may be acquired, hearing testing should be conducted throughout infancy and childhood.

What are important directions for future research?

The report calls on researchers to evaluate existing auditory-testing technologies, explore new technologies offering better means of testing, and continue cost-effectiveness studies, emphasizing how important it is to parents and professionals to identify children with hearing disabilities early.

The consensus report represents a significant effort by a group of experts to alert us to the incidence of hearing disabili-

ties in our patients. It provides an overview of etiologies and evaluation methods.

However, the report also should have stressed that in any screening program, the youngest (preterm), smallest, and sickest neonates are more likely to fail auditory screening tests. Likewise, screening normal newborns who frequently are discharged at less than 24 hours of age would probably raise the false positive results—especially if the EOAE technique is used—to an unacceptably high level.

In addition to selecting the best screening method, we must carefully rethink the best time to screen and not just consider the accessibility factor. The report is premature in suggesting that EOAE replace the ABR or, better yet, the ALGO-1, as the screening technique for newborns.

References

1. A multiple-source method for studying the prevalence of developmental disabilities in children: The Metropolitan Atlanta Developmental Disabilities Study. *Pediatrics* 1992; 89:624-30.
2. National Institutes of Health. *Consensus Development Conference Statement on Early Identification of Hearing Impairment in Infants and Young Children*. June 16, 1993.
3. Joint Committee on Infant Hearing: position statement. *Pediatrics* 1982; 70:496.
4. Personal Communication. B.S. Herrman, Massachusetts Eye and Ear Infirmary. August 1993.

FRED J. HELDRICH, M.D.

Dr. Heldrich is associate professor of pediatrics, Johns Hopkins University School of Medicine. ■

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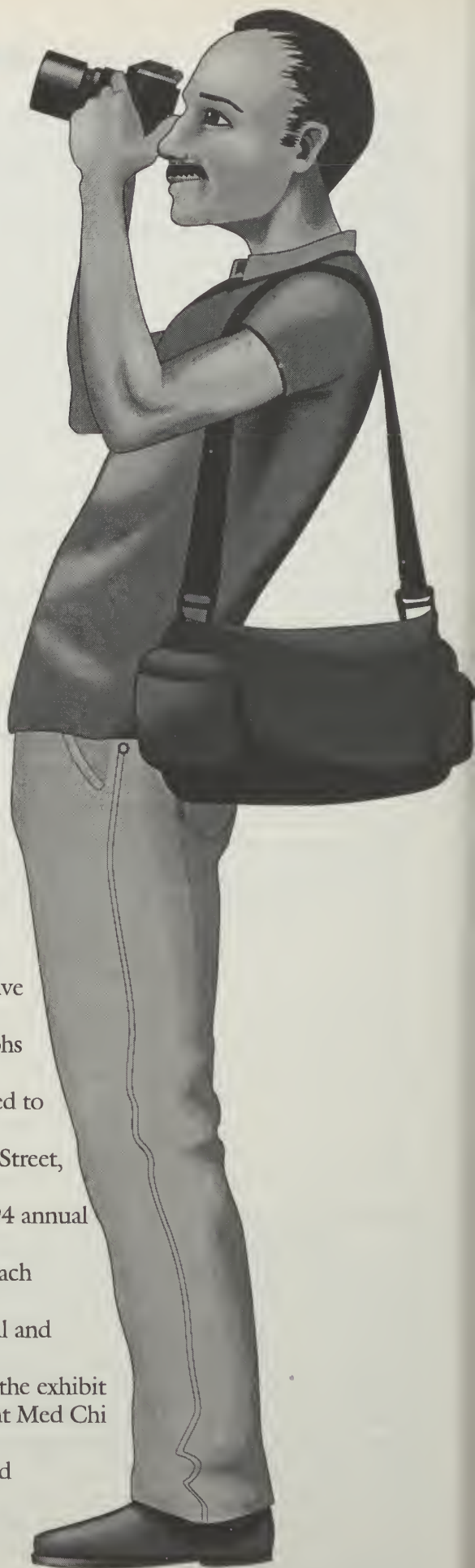
Enter the Fourteenth Annual Med Chi Photo Contest!

Deadline for entries is Friday, March 25, 1994.
Two categories: black & white OR color.
Open to all Med Chi and Auxiliary members.
First and second prizes awarded in each category.
All entries will be displayed at the 1994 annual
meeting at the Ramada Convention Center,
Hagerstown.

Photo Contest Rules:

Eligibility: All members of Med Chi and members of the
Auxiliary may enter. Professional photographers may not enter.
Members of the Photo Contest Committee and their families are
not eligible.

1. Photographs may be submitted in two categories: black and
white OR color
2. Limit: three entries per person.
3. Prints only; prints smaller than 8" x 10" or larger than 11" x 14"
will not be accepted. If your favorite shot is a slide, you must have
a print made within this size range to enter the contest.
4. Entries must be matted or dry mounted. No framed photographs
will be accepted.
5. Entries must have name, address, and telephone number attached to
the back of each photograph.
6. Entries may be mailed or brought to Med Chi, 1211 Cathedral Street,
Baltimore, MD 21201 by 5:00 pm on March 25.
7. Photographs entered in the contest will be on display at the 1994 annual
meeting.
8. Prizes will be awarded to the first and second place winners in each
category.
9. Winners will be announced at the annual meeting of the Medical and
Chirurgical Faculty, May 12-14, 1994.
10. Photographs will not be mailed back. They may be claimed at the exhibit
area at the close of the annual meeting at noon on May 14 or at Med Chi
thereafter.
11. Med Chi does not guarantee against loss or damage of any kind
to the photographs submitted to the contest.



Book Reviews

"Frostbite." *Alaska Medicine*. Volume 35, Number 1, 1993. 144 pages.
\$10.00 (single issue).

Book reviews rarely deal with articles published in medical journals. In this case, an exception has been made to the rule. The Alaska State Medical Association—in conjunction with the American Society for Circumpolar Health—has devoted a full issue of the journal *Alaska Medicine* to the principles of frostbite management.

This publication begins with an overview of frostbite treatment. The first three historic papers are reprinted from the introductory issue of *Alaska Medicine*, published in March 1960.

At that time, there were only 100 members of the Alaska State Medical Association. William J. Mills, M.D., was one of those members, was the first editor of *Alaska Medicine*, and was a man obsessed with improving the care of frostbite victims—most of whom became severely disabled as a result of cold trauma, inappropriate therapy, and subsequent amputations.

Frostbite occurs at temperatures that are low enough to cause extracellular ice crystals to form. The freezing point of human tissue is around -2°C to -5°C (23°F to 28°F). Dr. Mills observed that human tissue that is **slowly frozen**, is maintained at temperatures of -2°C to -5°C for prolonged periods, and is **slowly rewarmed** was most likely to suffer serious thermal complications. Earlier forms of therapy included sympathetic blockade, vasodilators, anticoagulants, and corticosteroids. These were almost totally ineffective.

Mills, who is currently director of the Center for High Latitude Health Research at the University of Alaska, reasoned that **rapid rewarming** made physiologic sense. He began treating patients with whirlpool baths kept at temperatures of 110°F to 118°F (43°C to 48°C). These temperatures were too warm, however, and occasionally resulted in augmenting the original cold injury.

Currently, temperatures of 100°F to 106°F (37.7°C to 41.1°C) are used, along with ultrasound therapy and an absolute rule of **no debridement**. This has enhanced survival, increased limb preservation, and diminished disability.

Alaska Medicine provides insight into the development of a contemporary treatment for this uncommon and unique thermal injury. The accompanying color photographs are splendid, albeit—forgive the pun—chilling, and the text easily read, although often redundant.

The problem of cold trauma raises the larger enigma of human residence within an environment hostile to its existence. The cases reported are a testimony to humankind's endurance at these extremes of physiologic stress. It further documents the indefatigable persistence of medical science and the dedication of physicians who conduct the research.

BARTON J. GERSHEN, M.D.
Rockville, Maryland ■

Office Orthopaedics. Michael L. Dvorkin. Norwalk, Connecticut: Appleton and Lange. 1993. 295 pages. \$49.95

The terse comment of Sergeant Joe Friday of "Dragnet," "Just the facts, ma'am," adequately describes *Office Orthopaedics*. This is a first-rate, information-packed, educational textbook about the common diseases and injuries encountered in the office of a practicing orthopaedist. The book was written specifically for internists, family practitioners, residents in these specialties, and, above all, medical students.

Individuals in these groups will have had little previous exposure to orthopaedics during medical school or subsequent periods of training. Dvorkin seeks to present the more commonly en-



Michael L. Dvorkin, M.D.

countered problems in a clear, concise text. Each of the 14 chapters is devoted to a single anatomic area. Line drawings and photographs excellently depict the normal anatomy and pathologic changes incident to disease or injury. The author plainly states that his book is not a compilation of all orthopaedic knowledge. The problems are presented, however, in a

basic and logical fashion and introduce the reader to the language of the specialty.

Algorithms detailing the diagnosis and therapy of conditions are presented. A satisfactory number of current references follows each chapter, but, unfortunately, they are not interfaced with the text. A good index, however, helps locate specific material.

Dvorkin is well qualified to author this book. He is certified by the American Board of Orthopaedics and is a practicing orthopaedist in the Baltimore area.

The book will find ready use by all medical personnel who wish to know more about specific orthopaedic diseases and injuries. The material should be particularly welcomed by medical students.

JOSEPH M. MILLER, M.D.
Timonium, Maryland ■

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Med Chi library moving toward the year 2000: online information sharing is the key

Med Chi's library continues to take advantage of advances in information technology. As we look toward the year 2000, the library is well positioned to participate in any statewide resource-sharing projects that develop.

Traditionally, Maryland has had a rich variety of libraries, with resource sharing and cooperative agreements preceding any formal network. The tremendous recent growth in information technology has made computer use an obvious choice for future sharing and communication among libraries. Today, even the smallest libraries in the state often have access to a computer.

Many library users have grown accustomed to computers in school and on the job. Most physicians are aware of the bibliographies that can be obtained from the Medline database and others like it. They may not realize, however, that many of the article photocopies they request are secured by their hospital or university library through the National Library of Medicine (NLM) Docline system or through the Milnet system developed by Maryland's State Library Resource Center.

Any plan to guide Maryland libraries toward the year 2000 must take advantage of information technology and the networks and databases already in existence. The Maryland State Library Network has developed an ambitious plan to interface local online library systems and link existing files and databases. The plan is called *Toward the Year 2000: A Strategic Plan for the Maryland State Library Network*.

The basis for this plan is the Seymour Project, an electronic infrastructure that will eventually connect all libraries in Maryland and allow access to the Internet (a worldwide network of networks). Named for a fictitious Labrador retriever, the Seymour Project will provide cost-effective telecommunications between users and resources, as well as services for resource sharing and information retrieval.

Through the cooperation of the state's Division of Library Development and Services and the Computer Science Center at the University of Maryland at College Park, a Seymour demonstration project called the Puppy Project is now available. Puppy files currently include all of Shakespeare's works, several online library catalogs, US presidents' press releases, and National Weather Service information. Plans to add legislative actions in Maryland, community information and referral directories, and other files are underway.

Because the Puppy Project Task Group is interested in experimenting with different kinds of files and databases, Med Chi's Music Medicine Clearinghouse was recently given a unique opportunity. The clearinghouse's bibliographies on the occupational diseases of musicians were included as a Puppy file in August and can be searched using the University of Maryland's GOPHER software. This software does not actually index the articles but does provide rough title word and author searching. Regular updating of the clearinghouse's bibliography file included on Puppy is being scheduled.

While the music medicine file on Puppy is not as sophisticated as some other related online databases, further work will be conducted if there is user interest. The Division of Library Development and Services has already used the music medicine file in presentations to various library groups as an example of what Seymour will be able to do. Through the Internet doorway, the bibliographies developed by Med Chi's Music Medicine Clearinghouse are now available to anyone in the world with the needed computer equipment.

The Seymour plan has caused Med Chi library staff to rethink some cataloging decisions and routines. Most academic and public libraries in the United States, as well as many others throughout the world, catalog books according to the MARC standard. This machine-readable cataloging standard was developed by the Library of Congress in the 1960s. Unfortunately, at practically the same time, NLM developed its Elhill system for Medline and its book counterpart, Catline. Cataloging records retrieved from Catline look much like a simple MARC record, but do not adhere strictly to that standard.

For a number of years, this was not a problem for medical libraries such as Med Chi. However, in the last decade, budget and staffing cuts have made cooperation and resource sharing with academic and public libraries increasingly important. Also, many health professionals are now crossing over into related disciplines, such as psychology, sociology, history, and business management. (The occupational diseases of musicians—which is a primary focus of the Music Medicine Clearinghouse—is a prime example of a highly interdisciplinary subject.)

In 1989, Med Chi purchased computerized cataloging software from Datatrek, Inc. The main objectives were to eliminate a large card catalog with many errors, reclassify

the collection using the NLM classification system, and save staff time. We also hoped to share our holdings, especially the history of medicine collection, through the statewide network. Initially, we based our cataloging records on those in the NLM Catline. While we sometimes made a few changes in the record, we could still say our cataloging was based on the "authority" of NLM.

However, as the Seymour planning progressed, it was announced that the MARC format would be the standard for cataloging records on the statewide network. Our reliance on the NLM Catline became problematic. For larger medical libraries, such as those at Johns Hopkins University and the University of Maryland, this was not a concern. As part of university-wide library systems, they have access to large bibliographic utilities, such as OCLC or RLIN. These utilities provide cataloging records in the MARC format. The expense involved with these large utilities was prohibitive for Med Chi.

However, there is a smaller company, Marcive, that can provide cataloging records of NLM holdings in the MARC

format relatively inexpensively. Datatrek has also developed upgraded catalog software that will support the MARC standard. Our cataloging records will now be in the MARC format, allowing us to be compatible with any future Seymour requirements.

Beginning in January 1994, all new books are cataloged using the MARC version of NLM records. Due to budget and staffing limitations, conversion of older online and card catalog records will probably not happen for some time. However, this is a beginning.

As our bicentennial approaches, the Med Chi library is taking advantage of as much of the information technology boom as possible. Through increased automation, we strive to provide users with rapid, easy access to information, materials, and services from any reasonable source. The ultimate goal is to fulfill the user's request as quickly and efficiently as possible.

SUSAN HARMAN, M.S.L.S., M.Ed.

Ms. Harman is associate librarian and coordinator of the Med Chi Music Medicine Clearinghouse. ■



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CMA, which has over 30 years of experience conducting short-term medical missions, will provide all training and administration.

For more information or to donate funds for medicine, please contact CMA, P.O. Box 3501, Seal Beach, CA 90740 or call 310-592-3791.

Minutes of the 342nd session of the House of Delegates

— *Semiannual Meeting, September 11, 1993* —

□ **CALL TO ORDER**

The 342nd session of the House of Delegates was called to order by the president and chairperson, Joseph Snyder, M.D., at 1:50 p.m. in the Sheraton Conference Center in Ocean City, Maryland.

○ **INVOCATION**

Leslie R. Miles, Jr., M.D., chairperson, Committee on Medicine and Religion, delivered the invocation.

□ **ANNOUNCEMENTS**

The chairperson drew the delegates' attention to the announcements contained in the agenda for the call of the meeting and reminded them that when they had the privilege of the floor, they were to announce their name and component medical society.

□ **REMARKS OF THE PRESIDENT**

Dr. Snyder noted that the Executive Committee had worked extremely hard between May 1 and today. Dr. Snyder thought that there was a new spirit of unity and cooperation within Med Chi. He noted that the Executive Committee, along with the Legislative Enhancement Committee, had worked diligently to select a lobbyist who would serve the best interests of the organization. Dr. Snyder went on to thank those involved, particularly Jose M. Yosucio, M.D., chairperson of the Legislative Enhancement Committee.

The chairperson noted that the new lobbyist, Jay Schwartz, Esq., will represent Med Chi very well in Annapolis. The chair introduced Mr. Schwartz, who gave a brief summary of his background and outlined his plans for building on Med Chi's past in Annapolis and involving as many people as possible, including the component and specialty societies, with whom he will be meeting on a regular basis.

Dr. Snyder introduced guests present at today's meeting including: Donald "Ted" Lewers, M.D., recently elected to the AMA's Board of Trustees; Donald Palmisano, M.D., AMA delegate from Louisiana; and Rose Mary Bonsack, M.D., a Maryland House of Delegates representative who brought greetings to Med Chi from the governor. Dr. Snyder also introduced David

Doman, M.D., who is running for a congressional seat in Maryland.

□ **APPROVAL OF MINUTES**

The minutes of the House of Delegates meeting held Friday, April 30, 1993; Saturday, May 1, 1993; and Wednesday, July 15, 1993, were presented. The minutes were approved by the Executive Committee on August 26, 1993. There were no corrections to the minutes as presented.

□ **PALMA E. FORMICA, M.D.**

Dr. Snyder introduced Palma E. Formica, M.D., AMA Board of Trustees. Dr. Snyder noted that Dr. Formica is an excellent example of the high caliber of women physicians in medicine and that she has been a champion for women physicians, an ardent advocate in the AMA's campaign against family violence, and an outspoken proponent for physicians' issues.

Dr. Formica thanked Med Chi for giving the AMA high caliber physicians such as Drs. Donald "Ted" Lewers, George Malouf, Sr., Henry Wagner, Jr., and Roland Smoot. Dr. Formica stated that she brought greetings from the "new" AMA board, which has minority, student, resident, and foreign medical graduate representation. Dr. Formica noted that the AMA was interested in how new health care policy would evolve. She stated that the AMA will send each physician a copy of the Clinton plan and that the AMA stands ready to support all physicians. Dr. Formica further remarked that doctors are the patients' advocates and that what is good for physicians will be good for their patients. She noted that over three million patients walk through physicians' offices daily.

Dr. Formica presented an AMA award to Med Chi for its outstanding leadership and direction in spearheading a statewide tobacco control program. On behalf of Med Chi, Dr. Formica was presented with a certificate of recognition by Dr. Snyder.

□ **MEDIA AWARDS**

Dr. Snyder announced the winners in the eighth annual Media Awards Program for Excellence in Medi-

cal Journalism. He noted that the winner in the non-daily newspaper and magazine category was Susan Thornton for the article, "The Vanishing Mind," published in the *Columbia Flier*. An honorable mention was presented to Diane Brown for her article, "I Can Hear," which appeared in the *Columbia Flier*. The winner in the radio category was John Stupak for "Physician-Assisted Suicide."

□ **MARYLAND MEDICAL JOURNAL**

Dr. Snyder announced that the article, "Strategies to reduce the high cost of patient noncompliance," by Debra Wertheimer, M.D., and Diane L. McNally, B.S. Pharm., had been selected as the best article by a physician published in 1992 in the *Maryland Medical Journal*. On behalf of Dr. Wertheimer, Ms. McNally accepted the award and noted the importance of physicians working with pharmacists in the prescribing of medication.

□ **ARTHUR T. KEEFE, JR., M.D.**

Dr. Snyder presented a certificate of recognition to Arthur T. Keefe, Jr., M.D., on behalf of all Med Chi physicians on the occasion of his retirement from Maryland Blue Cross and Blue Shield and for the many years he has given to the profession of medicine and to organized medicine, including serving as president of Med Chi in 1976. At the conclusion of the presentation, Dr. Keefe received a standing ovation from the House of Delegates.

□ **GOVERNOR'S AWARD TO MED CHI**

On behalf of the governor, Rose Mary Bonsack, M.D., presented Med Chi with a certificate of excellence for its efforts in the fight against tobacco.

□ **COUNCIL'S REPORT**

The chairperson asked Allan D. Jensen, M.D., chairperson of Council, for the Council's report. At the request of the respective component societies and by direction of Council, he requested, and it was approved, that the following members be granted emeritus membership:

Baltimore City

Adoracion B. Paulino, M.D.

Montgomery County

Michael M. Jaller, M.D.

Richard L. Levin, M.D.

Frank H. Small, M.D.

Wicomico County

Marcus D. Stephanides, M.D.

Dr. Jensen noted that it was necessary for Med Chi to know where it is, where it has been, and where it is going. To do this, Council approved the formation of a "Retreat Committee," of which Dr. Jensen is chairperson. He noted that the Retreat Committee had met and is submitting the following recommendations:

1. That the charge to the Retreat Committee be expanded to include reviewing the mission statement and goals of Med Chi;
2. That the ad hoc planning committee select the members of the Retreat Committee (not to exceed 15 members), with attention to geography, age, sex, and experience to assure appropriate representation;
3. That the retreat be held at a setting outside Med Chi;
4. That the retreat be held for one and one-half days;
5. That an experienced facilitator be used;
6. That the Retreat Committee report at the next Council meeting following the retreat;
7. That the Retreat Committee submit its report to the Policy and Planning Committee for review and comment; and
8. That six months after the Retreat Committee's report, the committees, task forces, or subcommittees assigned to work on the recommendations presented by the Retreat Committee be required to report to Council on their progress.

Dr. Jensen stated that funding was needed for holding the retreat. The approximate cost would be \$25,000, and a letter had been sent to the Med Chi Agency asking it to fund the endeavor. Dr. Jensen hoped that during the retreat, a mission statement and operation guidelines for Med Chi would be developed.

□ **PILOT NEEDLE EXCHANGE PROGRAM RESOLUTION**

The Baltimore City Medical Society presented a resolution to support the Baltimore City Health Department's pilot needle exchange program. The same resolution had been presented to Council the day before and had been approved for submission to the House. By two-thirds vote, the House agreed to hear the resolution.

It was stated that Med Chi's Legislative Committee had approved HB 357, which dealt with the pilot needle program, when it was presented during discussion of upcoming legislation during last session, and that Council had also approved the Legislative Committee's position

on the bill. The House of Delegates was asked to reaffirm that approval of having local health departments use needle exchange as an AIDS (acquired immunodeficiency syndrome) preventive. It was noted that there are 32 needle exchange programs nationwide in 27 cities, that there was a 33% decrease in the number of new AIDS cases in these areas, and that needle exchange appears to be both a primary and secondary prevention method. Included in the needle exchange program would be education regarding AIDS and drug treatment.

A motion was made to refer the issue to the Committee on AIDS to consider the matter and report to Council at its next meeting. Some members thought that the matter should be resolved today and not referred to the Committee on AIDS. The House of Delegates did not approve the motion. The Baltimore City Medical Society's resolution was approved by the House of Delegates as follows:

Whereas Baltimore City now has 3,500 reported cases of AIDS; IV [intravenous] drug users, their partners, and their offspring account for 70% of the new AIDS cases identified; one quarter of IV drug users are HIV [human immunodeficiency virus] positive; and it is estimated that four to five new HIV infections occur each day among IV drug users in Baltimore City; and

Whereas bleach and outreach efforts have not proven adequate to prevent the spread of the infection in IV drugs users; and

Whereas well-run needle exchange programs elsewhere in the United States have demonstrated that (a) HIV transmission among IV drug users has decreased, (b) addicts involved in such programs enter drug treatment more frequently than addicts not in such programs, and (c) fewer needles are found in streets and other public places; therefore, be it

Resolved, That the Medical and Chirurgical Faculty support the proposed needle exchange pilot project being developed by the Baltimore City Health Department, which will exchange needles and syringes and, at the same time, offer testing and screening for HIV infection and drug treatment referral.

❑ **RESOLUTION REGARDING ACTIONS OF PENNSYLVANIA BLUE CROSS AND BLUE SHIELD**

The medical societies in Montgomery and Prince George's counties stated they wished to introduce a resolution that asked Med Chi to support the efforts of these two counties regarding actions taken by Pennsylvania Blue Cross and Blue Shield to recoup monies from physicians for alleged overpayments in 1991-1993 for laboratory testing. Since the resolution had not been referred to the Reference Committee, a two-thirds vote was needed from the House of Delegates for the resolution to be presented. A two-thirds vote was received for the resolution to come to the floor. The resolution was approved as presented as follows:

Whereas physicians in Maryland are directed by Medicare to accept assignment as total payment for in-office laboratory testing; and

Whereas Pennsylvania Blue Cross and Blue Shield sets the Medicare reimbursement schedule for physicians, and

Whereas Pennsylvania Blue Cross and Blue Shield is now claiming to have overpaid physicians for laboratory tests in 1991-1993 and is demanding immediate repayment from those physicians;

So move that, Med Chi support the efforts of the medical societies of Montgomery and Prince George's counties to

- (1) Oppose the action taken by Pennsylvania Blue Cross and Blue Shield (and any similar action that may be taken by Maryland Blue Cross and Blue Shield) to recoup monies from physicians for alleged overpayments in 1991-1993 for laboratory testing; and
- (2) Work with Montgomery County and Prince George's County toward resolution of this issue.

❑ **LEGISLATIVE COMMITTEE REPORT**

Chairperson's report. Hilary T. O'Herlihy, M.D., chairperson, Legislative Committee, reported on the committee mandate to carry out the legislative business of Med Chi. He noted that in addition to himself, Drs. William F. Bruther and Arnold G. Levy were vice chairpersons of the committee. Dr. O'Herlihy stated that four subcommittees had been formed to review all legislation of interest to Med Chi as follows: boards and commissions, chaired by Joseph Fastow, M.D.; health insurance, chaired by David Davis, M.D.; medical practice, chaired by Howard Seigel, M.D.; and public health, chaired by Joseph Zebley III, M.D.

Dr. O'Herlihy stated that Joseph A. Schwartz III, Esq., Med Chi's new lobbyist, was introduced to the Legislative Committee at its first meeting on August 25, 1993. He also noted that component societies and specialty societies will be meeting regularly during the legislative session with the legislative team to ensure that they are kept informed of current developments. Also, there will be frequent fax communications from the Med Chi legislative office. Additionally, it is planned to involve hospital medical staff members throughout the state and members of the Auxiliary in the upcoming legislative efforts.

HB 1359. Dr. O'Herlihy introduced Angus Everton, Esq., general counsel, and asked him to give a report on amendments to HB 1359. Mr. Everton stated that at a recent Executive Committee meeting, it was the consensus of the committee members that amendments to HB 1359 should not be submitted directly to the legislature because several members of the Executive Committee had been informed, in conversations with John Colmers, executive director of the Health Care Access and Cost Commission (HCACC), and Delegate Casper Taylor

Jr., sponsor of the bill, that the legislature would not be open to any substantive amendments to this bill. He noted that Delegate Taylor had stated that the legislature would not look favorably upon many submissions because it wishes to give the HCACC an opportunity to solve its problems with the bill by regulation first.

Marianne Benkert, M.D., president, Baltimore County Medical Association (BCMA), noted that the county had spent over 300 hours reviewing the bill and asked that two amendments from BCMA be submitted to the HCACC (Section 19-1507 and Section 19-1508) as amendments. Dr. Snyder stated that he did not think that the Executive Committee would have any problem with referring these two amendments to the HCACC.

Albert Blumberg, M.D., Baltimore County, inquired whether all the other amendments should be accepted as Med Chi policy. It was noted that the Legislative Committee would be reviewing all amendments during its regular meetings.

The House of Delegates approved the Executive Committee's recommendations that Med Chi be very selective in the amendments it presents and that the lobbyist and general counsel should discuss with John Colmers how Med Chi's amendments should be presented. The House of Delegates thought that it was in the collective interest of Med Chi to move forward.

□ **BYLAWS**

Ramsay Farah, M.D., chairperson, Bylaws Committee, noted that the committee had met for several hours to analyze what was needed to improve the bylaws. However, because Council had approved the formation of a Retreat Committee to look at the organization, the Bylaws Committee decided to withhold any changes to the bylaws until the work of the Retreat Committee comes to fruition.

□ **COMMITTEE REPORTS**

The chairperson directed the House of Delegates to the listing of annual reports of committees that appeared in the September 1993 issue of the *Maryland Medical Journal*. Dr. Snyder noted that there were no recommendations or resolutions contained in those reports that had not been acted upon during the annual 1992-1993 year.

□ **MARYLAND MEDICAL POLITICAL ACTION COMMITTEE**

Frederick Hatem, M.D., chairperson, Maryland Medical Political Action Committee (MMPAC), noted that the MMPAC report was available to all members and

noted the importance of this organization to Med Chi's members.

□ **TREASURER'S REPORT**

The chairperson recognized Carol W. Garvey, M.D., treasurer, for her report. Dr. Garvey noted that Med Chi's books and records had been examined by a certified public accounting firm—Nadine/Lean, and she read the auditors' certification statement for 1992. Dr. Garvey then asked for unanimous consent of the accountants' certification with respect to the annual report and received it.

Dr. Garvey introduced the new controller for Med Chi, Glen C. Burger, C.P.A., who noted his gratification for being selected to fill such a prestigious position. Mr. Burger also summarized his current financial activities and noted that he has saved Med Chi over \$2,500 by having fees reduced by banks and was now looking into Med Chi's investments. Mr. Burger also was increasing accountability and installing safeguards in the Finance Department.

Dr. Blumberg stated that the surplus amount had not been identified and requested that it be noted. Mr. Burger noted that he was still updating all the information and would provide the information as soon as it was available.

Dr. Garvey remarked that there were no plans for a dues increase this year even though there had not been an increase in over 14 years, and Med Chi has one of the lowest dues in the federation. However, the Finance Committee believes it needs to obtain a clearer understanding of Med Chi's financial status before it can make a recommendation about dues.

□ **POLICY RESOLUTIONS**

The chairperson asked the secretary, Paul A. Stagg, M.D., to read the staff report on the review of policy resolutions. It was noted that all policies are to be reviewed five years after adoption. Therefore, policies adopted in 1988 would be reviewed.

The House approved the filing of the following resolutions adopted in 1988: 1A/88, 2A/88, 1S/88, 2S/88, 5B/88, 6S/88, and 7S/88. The House reaffirmed the following resolves as follows:

Resolution 3S/88

Resolved, That Med Chi strive to remove discrimination in residency programs, examination eligibility requirements, medical staff and academic appointment and professional society memberships; and be it further

Resolved, That Med Chi join with medical and specialty societies to remove discrimination in licensure requirements based upon the geographic location of the medical school.

Resolution 10S/88

Resolved, That the Medical and Chirurgical Faculty of Maryland urge Maryland congressional representatives or demand that the Department of Health and Human Services and the Health Care Financing Administration, at all times, distinguish between medical doctors and all other health care providers and discontinue the use of the generic and all-inclusive term "provider" when reporting or referring to costs of physician services.

Resolution 11S/88

Resolved, That the Medical and Chirurgical Faculty of Maryland assist the various educational systems in Maryland in the development of appropriate and intensive educational programs designed to educate all citizens, especially school children, regarding the dangers of this infectious disease and its transmission; and *Resolved*, That Med Chi and its component societies advocate appropriate funding from state and local governments for the dissemination of AIDS public education; and be it further *Resolved*, That Med Chi and its component societies support any legislation that would enhance education on the prevention of AIDS.

□ REFERENCE COMMITTEE

Murray Kalish, M.D., chairperson, Reference Committee, presented the committee's report. He noted the Reference Committee met on August 16, 1993, to hear two resolutions—one submitted by the Baltimore City Medical Society and the other by the Baltimore County Medical Association. The resolves of the resolution presented by Baltimore City were as follows:

Resolved, That the Medical and Chirurgical Faculty support local and state legislation to prohibit smoking in all public places, restaurants, bars, and workplaces in Maryland; and be it further

Resolved, That the Medical and Chirurgical Faculty support the efforts of component medical societies to have enacted legislation or regulations prohibiting smoking in public places, restaurants, bars, and workplaces by providing oral or written testimony before local or state legislative bodies or governmental agencies.

Dr. Kalish noted that the Reference Committee recommended that the House of Delegates adopt the resolution. A motion was made and approved to amend the resolves by deleting in the first and second paragraphs "restaurants, bars, and workplaces." The amended resolutions were adopted as follows:

Resolved, That the Medical and Chirurgical Faculty support local and state legislation to prohibit smoking in all public places in Maryland; and be it further

Resolved, That the Medical and Chirurgical Faculty support the efforts of component medical societies to have enacted legislation or regulations prohibiting smoking in public places by providing oral or written testimony before local or state legislative bodies or governmental agencies.

Dr. Kalish then presented the resolves from the resolution submitted by the Baltimore County Medical Association as follows:

Resolved, That this House of Delegates direct the officers, Legislative Committee, and staff of the Medical and Chirurgical Faculty to oppose any legislation or regulation that may cap fees or prohibit balance billing for any physicians in Maryland, thereby preserving the physician's right to establish and collect his/her own fees; and

Resolved, That this House of Delegates direct the officers, Legislative Committee, and staff of the Medical and Chirurgical Faculty to work for the amendment or repeal of any section of current Maryland law that may establish a cap on fees or prohibit balance billing for any physician in Maryland, thereby preserving the physician's right to establish and collect his/her own fees.

Dr. Kalish noted that the resolution concerned a physician's right to establish his/her own fees for services rendered and to contract individually with patients, third-party carriers, or government programs; required Med Chi to oppose any legislation or regulation that may cap fees or prohibit balance billing unless each *individual physician* consents; and required Med Chi to work to amend or repeal any section of current Maryland law that may establish a fee cap or prohibit balance billing unless physicians consent.

Dr. Kalish stated that this was the second time the Reference Committee had reviewed this resolution and that while some words were changed from the original resolution, the resolution would still tie the hands of the officers, staff, and the Legislative Committee in their legislative negotiations. Therefore, in order not to limit Med Chi in its negotiations and to preserve physicians' rights, the Reference Committee had recommended an amendment to delete the word "oppose" on line 14 and add the word "modify" or "modulate" in its place. However, this wording was not accepted by the Baltimore County Medical Association. Dr. Kalish further remarked that the Reference Committee recommended adoption of this resolution by the House, but the recommendation was not unanimous because of the concern about the word "oppose."

At this point, Dr. Blumberg presented an amendment to the resolution that read as follows:

Resolved, That this House of Delegates reaffirm AMA and Med Chi policy opposing caps on fees and prohibitions against balance billing and its support for the physician's right to establish and collect his or her own fees; and be it further

Resolved, That the Medical and Chirurgical Faculty of Maryland strive for the modification of existing Maryland laws and regulations that may establish caps on fees or prohibit balance billing other than the caps associated with the Medicaid program.

The chairperson accepted the amendment as a friendly amendment. A motion was made, seconded, and passed to add the words "or future" after the word "existing" in the last resolve. The amended resolves were adopted as follows:

Resolved, That this House of Delegates reaffirm AMA and Med Chi policy opposing caps on fees and prohibitions against balance billing and its support for the physician's right to establish and collect his or her own fees; and be it further

Resolved, That the Medical and Chirurgical Faculty of Maryland strive for the modification of existing or future Maryland laws and regulations that may establish caps on fees or prohibit balance billing other than the caps associated with the Medicaid program.

❑ **OTHER BUSINESS**

Comments of chairperson. The chairperson noted that there appeared to be a new spirit of cooperation at Med Chi and that members appeared to be working together in a cohesive fashion.

Comments of Alex Azar, M.D. Alex Azar, M.D., member of the Health Care Access and Cost Commission (HCACC), summarized a recent meeting of the HCACC where few physicians were present to discuss health system reform. Dr. Azar thought that this spoke very poorly of organized medicine and noted that it was important for physicians to become involved in this political process. Dr. Azar requested that the components be faxed the schedule of these meetings.

Special thanks to staff. Paul A. Stagg, M.D., secretary, referred to the very hard work of staff in preparing

for and documenting the many meetings that have occurred since May 1. He asked the House of Delegates to recognize the extraordinary effort, and the House of Delegates gave a standing ovation to staff.

Technical advisory committees (TACs). Ramsay Farah, M.D., requested input to the TACs from the component medical societies.

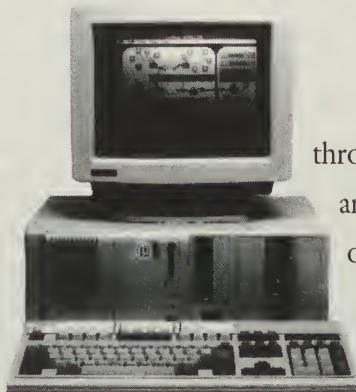
❑ **ADJOURNMENT**

There being no further business, the meeting was adjourned at 3:45 p.m.

Respectfully submitted,
PAUL A. STAGG, M.D.
Secretary

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Minutes of the Med Chi Council

— Semiannual Meeting, September 10, 1993 —

□ **CALL TO ORDER**

The meeting was called to order at 1:40 p.m. by the chairperson of Council, Allan D. Jensen, M.D., in the Sheraton Conference Center in Ocean City, Maryland.

□ **APPROVAL OF MINUTES**

The minutes of the July 15, 1993, meeting were approved as written.

□ **INTRODUCTION OF PALMA FORMICA, M.D.**

Dr. Jensen introduced Palma E. Formica, M.D., noting that she has been a member of the American Medical Association (AMA) Board of Trustees since June 1990. He said that Dr. Formica, a family practitioner from New Jersey, had served as an AMA delegate from New Jersey from 1983 to 1990 and was the past president of the New Jersey Medical Society. In addition, Dr. Formica is president of the AMA Education and Research Foundation (AMA-ERF), is a commissioner on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and serves on the Board of Directors of the New Jersey Medical Underwriters, to which she was elected secretary-treasurer in June 1990. Dr. Jensen noted that Dr. Formica was speaking at the scientific session on family violence and was a speaker at the plenary session on health system reform. The Council welcomed Dr. Formica.

□ **COUNCIL CHAIRPERSON'S REPORT**

Dr. Jensen stated that the Council's primary concerns were the problems facing Med Chi in respect to the drastic environmental changes in medicine today and that Med Chi needed new faces and to consider new ideas.

Introduction of staff. Chairperson of Council noted the management level staff changes at Med Chi during the last year. Dr. Jensen noted the hard work of Angelo J. Troisi, F.A.C.H.E., chief executive officer, and the promotion of Rose M. Matricciani, R.N., J.D., to chief operating officer earlier during the year. He then introduced other staff members: Joseph A. Schwartz III, Esq., recently hired lobbyist; Angus Everton, Esq., general counsel; Glen C. Burger, C.P.A., controller; and Ruth Seaby, director of communications. He also thanked

Carmine Valente, Ph.D., deputy executive director, for his work at Med Chi.

The chairperson asked Mr. Schwartz to address the Council. Mr. Schwartz discussed his background and his plans for the upcoming legislative session to give Med Chi the recognition it deserves in Annapolis. Mr. Schwartz noted that he had over 20 years of lobbying experience and that he considered it the highest honor to have been selected to be Med Chi's lobbyist. When the Maryland General Assembly convenes in January, Med Chi will be the voice to listen to on health care matters and will lead and structure the debates on health care issues. He noted that a successful year will require a lot of hard work. He has been meeting with the chairperson and vice chairperson of the Legislative Committee, as well as the subcommittees of the Legislative Committee. Everyone involved in the legislative process will be ready to go to work when the Maryland General Assembly convenes. Mr. Schwartz also noted that he will meet regularly with the component medical societies and the specialty societies.

Executive committee. Dr. Jensen related that there had also been many changes in the make-up of the Executive Committee: there are six new members.

□ **EMERITUS MEMBERS**

The following members were approved for emeritus membership as requested by their component medical society.

Baltimore City

Adoracion B. Paulino, M.D.

Montgomery County

Michael M. Jaller, M.D.

Richard L. Levin, M.D.

Frank H. Small, M.D.

Wicomico County

Marcus D. Stephanides, M.D.

□ **COMMITTEE ON PUBLIC HEALTH**

Martin P. Wasserman, M.D., chairperson, Committee on Public Health, presented the committee's recommendations:

1. That Med Chi support the Maryland Association of County Health Officers (MACHO) list as a reason-

able list of services to be provided by local health departments.

2. That Med Chi continue to participate in the Coalition for a Smoke-Free Maryland, but that Med Chi would not be the agent responsible for organizing and staffing the coalition.
3. That Med Chi support the six principles of the Coalition for a Smoke-Free Maryland.

Joseph Snyder, M.D., president, reported that the Executive Committee suggested approving the recommendations. Council approved all three recommendations.

□ **PUBLIC RELATIONS COMMITTEE**

Hiroshi Nakazawa, M.D., chairperson, Public Relations Committee, reviewed the committee's recommendations:

1. That Med Chi adopt the communications plan consisting of two parts:
 - a. Enhance the internal communications program as outlined on the attached plan; and
 - b. Hire an outside firm to assist in developing and coordinating a comprehensive public relations campaign to enhance the image of Maryland physicians.
2. That although Med Chi has no control over individual physicians choosing to advertise, component societies should be requested to refrain from providing endorsements when individual physicians are being promoted.

Dr. Jensen requested that each recommendation be considered separately and requested Dr. Snyder to report on the Executive Committee's deliberations of these items. Dr. Snyder noted that the Executive Committee accepted item 1a. Item 1b was tabled to give the new lobbyist and director of communications an opportunity to improve the image of Med Chi through their efforts, and item 2 was approved by the Executive Committee.

The Council adopted item 1a to enhance the internal communications program as outlined. A motion was made to amend item 1b by adding the word "Consider" at the beginning of the statement and changing the word "Hire" to "hiring." The Council approved the amendment to read as follows: *Consider hiring an outside firm to assist in the development and coordination of an overall, comprehensive public relations campaign designed to enhance the image of Maryland physicians.* The Council tabled the amended motion until the next meeting when the director of communica-

tions would present a report of public relations efforts to Council.

Item 2 was referred back to the Public Relations Committee to develop a framework regarding advertisements by physicians.

□ **COMMITTEE ON PHYSICIAN REHABILITATION**

In the absence of the chairperson of the Committee on Physician Rehabilitation, the Council chairperson called upon J. Richard Lilly, M.D., vice chairperson of Council, to present the following policy statement on physician use of alcohol in relationship to patient care:

The Faculty finds that it is totally unacceptable for a physician to drink alcohol in proximity to examining and treating a patient in any setting. The relationship between patient and physician is harmed by the patient being aware that the physician has recently used alcohol, as noted by an odor of alcohol, slurred speech, lack of motor coordination, or cognitive impairment. The use of alcohol in such situations is likely to lead to a reduction in quality of care and raises the likelihood of harm to the patient.

Therefore, the committee recommended the following:

1. Physicians will not drink alcohol at any time proximate to rendering patient care.
2. A physician on duty, on call, or planning to evaluate or treat a patient will not drink alcohol.
3. Medical staffs, hospitals, and other health care organizations should not serve alcohol at meetings or other gatherings held on their premises because of the possibility that physicians will soon after have contact with patients.

Dr. Jensen then called upon Dr. Snyder to report on the Executive Committee's review of the recommendations. Dr. Snyder reported that the Executive Committee found the word "proximate" in the first recommendation to be an ambiguous term. Furthermore, the Executive Committee thought it would be intrusive of Med Chi to suggest that other health care organizations and hospitals not serve alcohol. Therefore, the Executive Committee approved only the second recommendation which states: "A physician on duty, on call, or planning to evaluate or treat a patient will not drink alcohol."

Dr. Jensen suggested that the Council consider each recommendation separately. The council opposed item 1. A motion was made and passed to amend item 2 to read that *A physician on duty will not drink alcohol.* The amendment to the recommendation was approved. However, the Council opposed the

amended amendment and referred it back to the committee.

It was suggested that item 3 be referred to the Committee on Hospital Medical Staffs. Staff noted that this committee had already considered this recommendation and had opposed it. The Council voted in opposition to the recommendation.

❑ *NATIONAL ASSOCIATION OF MANAGED HEALTH CARE PROVIDERS*

Merrill Cohen, M.D., reported on the background of the National Association of Managed Health Care Providers. Issues discussed were provider agreements, managed care plans, typical covenants of health care, and negotiations and leverage.

Dr. Jensen called upon Alex Azar, M.D., first vice president, for his comments. Dr. Azar expressed his wish that Dr. Cohen take this presentation to the Health Maintenance Organization (HMO) Quality and Practice Parameter Development Committee of the Health Care Access and Cost Commission so that the committee could hear this information.

Dr. Azar further noted that through the efforts of Med Chi's general counsel, HB 1359 includes a statement that says: "The act exempts from antitrust laws the good faith activities of professional organizations undertaken in the furtherance of the compensation provisions of the act." Dr. Jensen thanked Dr. Azar for his comments, and a motion was made to accept Dr. Cohen's report and to send the report to the Legislative Committee for review.

❑ *FINANCE COMMITTEE*

The Council chairperson recognized Paul A. Stagg, M.D., chairperson of the Finance Committee. Dr. Stagg presented the Finance Committee's recommendations as follows:

1. That there be no dues increase at this time.
2. That a fiscal note be attached to every committee recommendation.

The Council chairperson noted that these recommendations had been presented to the Executive Committee at its August 26, 1993, meeting. The president informed the Council that the Executive Committee had approved both recommendations, and he noted that Med Chi's dues are the lowest in the 50 states and had not been raised in 14 years.

Arnold G. Levy, M.D., raised the issue of what would occur if the recommendation passed not to increase dues and it was determined that a public relations campaign

was necessary. He questioned if the increase in dues had to wait until the next House of Delegates meeting or if there was another mechanism to fund such a campaign.

The chairperson called upon the treasurer, Carol Garvey, M.D., to answer Dr. Levy. Dr. Garvey noted that Med Chi was looking at investments to maximize interest and was reviewing bank charges to lower costs. She stated that the Finance Department was in the middle of reorganizing and the new controller was examining Med Chi's sources of revenue in order to maximize investments and run a tight ship financially. Dr. Jensen stressed that the Council votes on the budget and has the prerogative of changing its mind about a dues increase at any time. Rose M. Matricciani, R.N., J.D., chief operating officer, informed the Council about Med Chi's current initiatives of reviewing all accounts and investments, streamlining operations, and providing for more accountability in grants to maximize administrative costs.

A motion was made, seconded, and approved to support both recommendations.

❑ *LEGISLATIVE COMMITTEE REPORT*

The Council chairperson called upon Hilary T. O'Herlihy, M.D., chairperson, Legislative Committee, to provide a report. Dr. O'Herlihy gave brief remarks and introduced Jay Schwartz III, Esq., to discuss this year's legislative initiatives. Mr. Schwartz noted that the guiding premise is that Med Chi is the leader of health care in Maryland. He stated that Med Chi will realize that goal through Legislative Committee meetings, meetings with specialty society lobbyists, meetings with the component societies, using computer and fax capabilities, synopsising bills, and working with the Health Care Access and Cost Commission. Mr. Schwartz ended by citing two Notre Dame football slogans, "Do a few things well," and "Luck is the residue of design."

❑ *AD HOC COMMITTEE TO ORGANIZE A RETREAT*

Dr. Lilly presided over this portion of the meeting and called upon Allan D. Jensen, M.D., chairperson, Ad Hoc Committee to Organize a Retreat, to present the committee's report. He noted that the Council had passed a motion to organize a retreat "for the purposes of examining the structure and operation of Med Chi to determine if that structure and operation is adequate to meet the needs of physicians and the public in the coming decade." A representative from each nominating group was selected to be a member of the committee as follows:

Allan D. Jensen, M.D., chairperson, Baltimore City
 Willie C. Blair, M.D., Prince George's County
 Louis C. Breschi, M.D., Baltimore County
 J. Roy Guyther, M.D., Southern Group
 Christian Jensen, M.D., Eastern Group
 Donald S. Stepita, M.D., Montgomery County
 Robert J. Thomas, M.D., Western Group

Dr. Jensen presented the committee's recommendations as follows:

1. That the charge to the Retreat Committee be expanded to include review of the mission statement and goals of Med Chi;
2. That the Ad Hoc Committee to Organize a Retreat select the members of the Retreat Committee (not to exceed 15 members), with attention to geography, age, sex, and experience to assure appropriate representation;
3. That the retreat be held at a setting outside Med Chi;
4. That the retreat be held for one and one-half days;
5. That an experienced facilitator be used;
6. That the Retreat Committee report at the next Council meeting following the retreat;
7. That the retreat committee submit its report to the Policy and Planning Committee for review and comment; and
8. That six months after submission of the Retreat Committee's report, committees, task forces, and subcommittees assigned to work on the Retreat Committee's recommendations be required to report to Council on their progress.

Dr. Jensen called upon Ms. Matricciani to present the information concerning the costs associated with holding a retreat. Ms. Matricciani reported on the cost of a facilitator and the expense associated with providing a hotel room, meeting room, meals, and parking for approximately 15 individuals.

Dr. Jensen noted that funding was needed to hold the retreat. The approximate cost would be \$25,000, and a letter had been sent to the Med Chi Agency asking if it would be able to fund such an endeavor. A motion was made and approved to accept the report and expend approximately \$25,000 for the retreat. Inherent in that motion was the understanding that if the Med Chi Agency could not support the retreat, the matter would be referred to the Finance Committee.

Dr. Jensen said he hoped that during the retreat, a mission statement and operation guidelines for Med Chi would be developed.

□ INFORMATIONAL ITEMS

Medical Mutual Liability Insurance Society of Maryland, Inc. (Med Mutual). Dr. Jensen called upon Angus

Everton, Esq., general counsel, who explained that during the last year, the Maryland Court of Appeals ruled that there was no cap on noneconomic damages in a wrongful death action. He then discussed the implications of this ruling on malpractice premiums and health care costs. Mr. Everton stated that Med Mutual plans to promulgate and introduce legislation to apply the cap on noneconomic damages to wrongful death actions, and he noted that the Executive Committee supported this endeavor and that the president had directed Jay Schwartz, Med Chi's lobbyist, and Angus Everton, Med Chi's general counsel, to work with Med Mutual to draw up legislation on this matter.

Dr. Jensen called upon Raymond Yow, M.D., Med Mutual C.E.O., to say a few words. Dr. Yow discussed Med Mutual's efforts in preparing legislation to rectify this problem by establishing a cap on noneconomic damages. He requested Med Chi's support and individual physician support.

Donald Stepita, M.D., president, Montgomery County Medical Society, questioned how renewal rates for malpractice insurance will be affected. Dr. Yow answered that next year, Med Mutual does not anticipate any increase.

Med Chi's initiative against family violence. Dr. Jensen noted that on September 8, 1993, Med Chi launched its Physicians' Campaign Against Family Violence at a press conference. The campaign entitled "Unlock the silence. The key is trust." includes an educational program that will focus on the vital role physicians can play in breaking the cycle of family violence through the physician/patient relationship. Dr. Jensen outlined the goals of the campaign and identified the participants.

Robert Wood Johnson grant. Dr. Jensen noted that the AMA will administer the Robert Wood Johnson grant program to help states fight tobacco use. The purpose of the grant is to strengthen state resources and enable community and regional groups to carry out comprehensive and highly visible tobacco prevention and control initiatives. Med Chi is applying for a grant.

Drug Enforcement Agency (DEA) response. Dr. Jensen said that the DEA had increased its application fee from \$60 to \$210 for a three-year registration for Schedule II through V controlled substances. Dr. Jensen explained that Med Chi, and the AMA had protested the increase. The DEA had responded that the registration fee had been increased to cover adequately the federal costs associated with the Diversion Control Program as mandated in the Department of Justice and Related

Agencies Appropriations Act. The AMA is currently pursuing the issue from a legal standpoint, and Med Chi is supporting the AMA's efforts.

Workers' Compensation Commission report. Dr. Jensen noted that through the efforts of the Committee on Managed Care and Third-Party Liaison, the Workers' Compensation Commission has asked Med Chi to review and comment on its annual report. Dr. Jensen called upon Ms. Matricciani who reported that Med Chi provided the commission with an extensive review of the report.

Committee on Computers in Medicine. The Committee on Computers in Medicine will survey physicians about computer use in medical offices. The survey will be printed in the *Maryland Medical Journal (MMJ)* as approved by the Executive Committee. Members of Council were asked to make their colleagues aware that the survey will be in the September issue of the *MMJ*.

Committee on Managed Care and Third-Party Liaison. Dr. Jensen said that the Executive Committee had approved a survey on managed care to evaluate physicians' perception of the services provided by managed care and insurance entities. This survey will be designed by Carmine Valente, Ph.D., deputy executive director. Council members were told that if they had any suggestions for the survey, they should forward them to Dr. Valente by September 30, 1993.

X-ray aide course and test. Dr. Jensen explained that legislation had passed that required individuals taking x-rays in physicians' offices to take a course and pass a test. Dr. Jensen called upon Ms. Matricciani to provide an update. Ms. Matricciani explained that the first course and examination for x-ray aides in physicians' offices was given by several community colleges. The examination, however, was flawed, and a review course and free repeat examination will be offered on October 2 at 10 a.m. at community colleges to students who failed the first exam. She also noted that because the students expressed concern about the lack of laboratory hours and suggested lengthening the course, the next course that will be offered, which has been approved by the Maryland Radiological Society in consultation with the Maryland Society of Radiologic Technologists, will be extended to 70 hours. Med Chi will be mailing information on the course times and community colleges offering the course (the courses are expected to begin in October) as soon as the information is available.

Report covering peer review and physician rehabilitation funds. Dr. Jensen told the Council that a memorandum of understanding (MOU) between Med Chi and

the Board of Physician Quality Assurance (BPQA) regarding funds for Med Chi's peer review and physician rehabilitation programs was approved by Med Chi and the attorney general for BPQA and is now before the Department of Health and Mental Hygiene. The \$100,000 peer review enhancement contract has been finalized. No money has been received from the enhancement contract. It was noted that the enhancement contract funds will not be retroactive. Med Chi is currently undergoing a state audit, and the contract will not be signed until after the audit.

Dr. Jensen said that in accordance with the MOU, Med Chi has forwarded a budget for the peer review and physician rehabilitation programs to the BPQA. The state auditors expect to be at Med Chi through the month of November conducting their on-site audit. After the on-site audit, the audit report must be approved before it is submitted to the legislature in January. No funds for the peer review and physician rehabilitation programs will be forthcoming until the audit is completed.

Dr. Blumberg asked if the funds that had not been released were just enhanced funds or funds from 1992 as well as 1993. Ms. Matricciani responded that the \$100,000 enhancement funds had not been received, and the BPQA decided they were not retroactive even though Med Chi had worked on the peer review manual and the increased cases from BPQA.

□ NEW BUSINESS

Pilot needle exchange program. The Baltimore City Medical Society presented a resolution to support the Baltimore City Health Department's pilot needle exchange program as follows:

Whereas Baltimore City now has 3,500 reported cases of AIDS [acquired immunodeficiency syndrome]; IV [intravenous] drug users, their partners, and their offspring account for 70% of the new AIDS cases identified; one quarter of IV drug users are HIV [human immunodeficiency virus] positive; and it is estimated that four to five new HIV infections occur each day in IV drug users in Baltimore City; and

Whereas bleach and outreach efforts have not proven adequate to prevent the spread of the infection in IV drugs users; and

Whereas well-run needle exchange programs elsewhere in the United States have demonstrated that (a) HIV transmission among IV drug users has decreased, (b) addicts involved in such programs enter drug treatment more frequently than addicts not in such programs, and (c) fewer needles are found in streets and other public places; therefore, be it

Resolved, That the Medical and Chirurgical Faculty support the proposed needle exchange pilot project being developed by the Baltimore City Health Department which will exchange needles and syringes and, at the same time, offer testing and screening for HIV infection and drug treatment referral.

A motion that Med Chi take the AMA's position and wait and see if the program works was made and

seconded, but was not approved. A motion that the matter would not be made a lobbying issue was made, seconded, and passed. However, the Council reconsidered and presented another motion to rescind the motion, which was seconded and passed. A motion was made, seconded, and passed to send the resolution to the House of Delegates (which would be meeting the next day) for its consideration.

□ **RESOLUTION REGARDING ACTIONS OF**

PENNSYLVANIA BLUE CROSS AND BLUE SHIELD

On behalf of Montgomery County and Prince George's County medical societies, Arnold G. Levy, M.D., stated that the counties wished to introduce a resolution that asked Med Chi to support the efforts of these two counties regarding actions taken by Pennsylvania Blue Shield (PBS) to recoup monies from physicians for alleged laboratory testing overpayments in 1991-1993. Dr. Levy related the events surrounding the recoupment, and noted that the Health Care Financing Administration (HCFA) admitted that PBS provided the physicians with incorrect billing instructions. Dr. Levy made a motion that the following resolution be supported:

Whereas physicians in Maryland are directed by Medicare to accept assignment as total payment for in-office laboratory testing; and

Whereas Pennsylvania Blue Cross and Blue Shield sets the Medicare reimbursement schedule for physicians; and

Whereas Pennsylvania Blue Cross and Blue Shield is now claiming to have overpaid physicians for lab tests in 1991 through 1993 and is demanding immediate repayment from these physicians, so move

That, Med Chi support the efforts of Montgomery County and Prince George's County medical societies to

1. Oppose the action taken by Pennsylvania Blue Cross and Blue Shield, and any future similar action that may be taken by Maryland Blue Cross and Blue Shield to recoup monies from physicians for alleged overpayments in 1991 through 1993 for laboratory testing, and
2. Work with Montgomery County and Prince George's County toward resolution of this issue.

The motion was seconded, and Dr. Levy asked Ms. Matricciani to address the Council on this issue. Ms. Matricciani extended her thanks to Diane Briggs, executive director, Prince George's County Medical Society, and Ed Shanbacker, executive director, Montgomery County Medical Society, for bringing this issue to Med Chi's attention. Next, Ms. Matricciani noted the following:

1. Pennsylvania Blue Shield (PBS) did not follow a HCFA directive;
2. PBS miscalculated the payments;
3. PBS made the error, not the physicians;
4. Med Chi immediately contacted HCFA's regional

office. The regional administrator responded and asked Med Chi to notify the physicians that they did not have to pay back the money within 30 days;

5. The involvement of the Office of the Inspector General (OIG) raised fraud and abuse concerns;
6. AMA became involved because the problem extended to New Jersey, Pennsylvania, Virginia, Washington, DC, and Delaware;
7. AMA has met with HCFA administrator, Bruce Vladeck;
8. AMA supports the physicians in this effort and believes that the physicians should not have to pay the recoupment; and
9. AMA will be convening a conference call on Monday to provide the states with an update on its progress.

The Council approved the resolution to be sent to the House of Delegates.

□ **NEGOTIATIONS BY MANAGED CARE FACILITIES AND HOSPITALS**

Dr. Jensen recognized Joseph S. Fastow, M.D., and asked him to address the membership. Dr. Fastow noted the proliferation of various network mechanisms that may involve proprietary ownership by physicians in hospitals and may involve physicians undertaking insurance functions. Dr. Fastow moved that the Council direct the Committee on Managed Care and Third-Party Liaison to begin to develop a strategy to serve as a clearinghouse about network development and be able to advise the Council and House of Delegates on these issues as they evolve. The motion was seconded and approved.

Report UU. Alex Azar, M.D., first vice president, AMA delegate, and a member of the Health Care Access and Cost Commission, noted that he had copies of *Report UU* from the AMA for distribution because the compensation proposal in HB 1359 mirrors the AMA's *Report UU* on compensation.

□ **ADJOURNMENT**

There being no further business, the meeting was adjourned at 3:30 p.m.

Respectfully submitted,
PAUL A. STAGG, M.D.
Secretary

Highlights: Executive Committee and Council Actions

— Executive Committee meeting, October 21, 1993 —

- President Joseph Snyder, M.D., noted that Med Chi had sent a letter to the *Washington Post* in response to an article on lab fees. Jay Schwartz, Esq., Med Chi lobbyist, noted that allied health groups would be joining Med Chi in writing letters to the Health Care Access and Cost Commission (HCACC) about the HEDIS document (Health Plan Employer Data and Information Set manual, version 2), a flawed document prepared by an organization run by the health maintenance organization (HMO) industry and large-scale employers.
- The Executive Committee voted that Med Chi should oppose the 14-digit unique identifying number for reporting HIV-positive infections and support a simpler reporting method, such as initials and birth date or name.
- Donald H. Dembo, M.D., presented an update on the Maryland Alliance for Healthcare. Because of funding limitations, the alliance will not be able to present the HCACC with a viable database that could be used in accordance with the mandates of HB 1359. The alliance's new goals are being developed. Dr. Dembo encouraged Med Chi's continued membership in the alliance.
- The Executive Committee supported the two recommendations from the Committee on Alcoholism and Chemical Dependency: (1) That the committee's name be changed to Committee on Addiction (the recommendation will be sent to the Bylaws Committee) and (2) that Med Chi join the Maryland Addiction Recovery Coalition (MARC).
- Ronald Cohen, M.D., chairperson, Committee on Peer Review, presented Med Chi's 1992 peer review statistics. In terms of physician disciplinary action, Maryland has moved from 37th place to 17th.
- Victor R. Hrehorovich, M.D., chairperson, Committee on Scientific Activity, reported that as a result of the meeting with the Accreditation Council on Continuing Medical Education (ACCME) and the excellent work of staff, he expected Med Chi to be taken off probation.
- The Committee on Scientific Activity was charged with presenting to the Executive Committee potential dates and locations for the annual and semiannual meetings for the next five years.
- The Executive Committee approved the *Maryland Medical Journal's* recommendation that Med Chi continue its relationship with the State Journal Group (a reorganization of the State Medical Journal Advertising Bureau).
- Ramsay Farah, M.D., provided an update on the actions of Med Chi's HMO Practice Parameter Technical Advisory Committee. In discussing the HEDIS document, the Executive Committee noted that it was important that Med Chi assume a leadership role on the health maintenance organization (HMO) issue; that the proposed questionnaire should include a global assessment of the HMO (e.g., courtesy, competency) and whether the HMO roster is provided to emergency rooms; that physicians should be wary of responding if the questionnaire is given to them directly by the HMO; that access issues are not included in the questionnaire (e.g., how long does it take a patient to obtain a hip replacement); that staff and nonstaff HMOs are different and should be evaluated differently; and that patient input was not included in the questionnaire.
- Joseph Fastow, M.D., chairperson, Medical Care Database Development Technical Advisory Committee (TAC), will be meeting with Mary Stuart, chairperson of the HCACC's data TAC, to provide questions for the database form. The HCACC is currently reviewing the Minnesota Integrated Data Initiative. The Executive Committee expressed concern that the HCACC's data TAC does not seem to understand all facets of the data issue.
- The Executive Committee approved the formation of an ad hoc committee to study the possibility of Med Chi forming an IPA (independent practice association). A maximum of \$5,000 was approved for the committee to solicit legal or other expertise.
- The Executive Committee voted to send a formal communication to the Maryland Academy of Family Physicians stating that Med Chi was sorry that its annual meeting would conflict with the academy's annual meeting and that Med Chi would like to work with the academy in the future when setting meeting dates.
- The Executive Committee voted to conduct one survey on IPAs and profiling and a separate survey on managed care.
- Carmine Valente, Ph.D., deputy executive director, noted that Daniel Kohn, M.D., chairperson, Committee on Specialty Societies, had indicated that the committee's

- request for a clipping service was no longer a priority.
- ❑ Dr. Dembo reported on Medmetrics' proposal for an "informed-like" corporation that would provide Med Chi members with benefits regarding profiling (cost would be approximately \$9 per member). The Executive Committee decided, however, that instead of spending \$120,000 on a profiling system, Med Chi would be better served by incorporating profiling into its IPA, if one is established.
 - ❑ Following a presentation by Angus Everton, Esq., Med Chi general counsel, on the information he had sent to the Health Resources Planning Commission regarding regulating gastrointestinal endoscopy, the Executive Committee voted that outpatient endoscopy should be deregulated as it pertains to physician offices and outpatient facilities.
 - ❑ Dr. Dembo reported on academic physician membership in Med Chi: 30% of physicians with privileges at

the University of Maryland are Med Chi members; 20% of those with privileges at Johns Hopkins are Med Chi members.

- ❑ Glen Burger, C.P.A., controller, reported on his review of the policy of other organizations with regard to reimbursing Executive Committee members for expenses. Dr. Snyder noted that in the past, only the president was paid for expenses at official meetings.
- ❑ The Executive Committee suggested that a letter be sent to a former committee chairperson, who had asked to be paid for services, indicating that service on a committee was voluntary.
- ❑ The Executive Committee voted that Med Chi's policy is that it does not support a single-payer system similar to the Canadian system, and that this policy could be reported to the legislature.
- ❑ The Executive Committee subsequently went into executive session.

———— *Executive Committee meeting, November 18, 1993* ————

- ❑ Thomas Garvey of Garvey Group presented information on how his association could help Med Chi develop a statewide IPA/HMO (independent physicians association/health maintenance organization). A feasibility study would cost approximately \$25,000. The cost to carry out the plan would be approximately \$250,000. Although Med Chi members could not be excluded from participating in an IPA set up by a medical society, there are means of disciplining physicians and retraining them, if needed. Medical societies that have successfully formed IPAs sell a maximum of three shares per physician so that no one has a controlling interest

(purchasing shares is not a prerequisite for a physician to participate in a medical society IPA). Since Maryland is a waiver state, hospitals may not be able to, or may not want to, decrease the rate they charge an IPA. It was decided that Med Chi Agency should be asked to undertake an IPA feasibility study.

- ❑ Hilary O'Herlihy, M.D., Legislative Committee chairperson, and Jay Schwartz, Esq., Med Chi lobbyist, provided a legislative update.
- ❑ The Executive Committee then met in executive session.

———— Celebrate Doctors' Day ————

March 30, 1994

Auxiliary

Doctors' Day—61 years of history

The first Doctors' Day observance was held on March 30, 1933, by the Barrow County Auxiliary in Winder, Georgia. The idea of setting aside a day to honor physicians was conceived by Eudora Brown Almond, wife of Dr. Charles Almond. The recognition occurred on the anniversary of the first administration of anesthesia by Dr. Crawford W. Long, in Barrow County, Georgia, in 1842. (This historic event occurred at a time when a surgeon was judged by speed, not skill, and when surgery was generally performed without any painkillers.)

On May 10, 1934, a resolution was adopted by the Georgia State Medical Auxiliary to pay tribute to the doctors by making March 30 the official Doctors' Day. The resolution was introduced to the Women's Auxiliary to the Southern Medical Association at its 29th annual meeting in St. Louis, Missouri, November 19-22, 1935. Since then, Doctors' Day has become an integral part of, and synonymous with, the Southern Medical Association Auxiliary (SMAA). Through the years, the red carnation has been used as the symbol of Doctors' Day.

In 1990, legislation was introduced in the House and Senate by Congresspersons Mike Parker (D-Mississippi) and G.V. Montgomery (D-Mississippi) and Senator Thad Cochran (R-Mississippi) to establish a national Doctors' Day. Following overwhelming approval by the United States Senate and the House of Representatives, President George Bush signed Public Law 101-473 on October 20, 1990, designating March 30 as "National Doctors' Day."

In Maryland, the Med Chi Auxiliary traditionally receives a governor's proclamation every year in recognition of Doctors' Day. All county auxiliaries celebrate Doctors' Day in their own special ways, including mammography screenings, international dinners, displays



Figure 2. Part of the Maryland contingent to the SMAA meeting in New Orleans: (L to R) Bobbie Niklewski, Washington County; Ginny Levikas, Baltimore County; Ching Barretto, Harford County; Betty Molz, Baltimore County; Mary Skipton, Prince George's County; and Helen Boyer, Montgomery County.



Figure 1. Ching Barretto stands behind Doctors' Day exhibits from Frederick, Harford, and Washington county auxiliaries.

in hospitals, breakfasts and lunches, "apples for docs" programs, special balloons, country western dances, special cards for retired physicians, "back to the 50s" dances, and donations to the American Medical Association Education and Research Foundation (AMA-ERF). The Southern Medical Association makes available to its auxiliary a \$300 allotment for the promotion of Doctors' Day, with the stipulation that an exhibit and a narrative description of the Doctors' Day project be on display at the annual meeting, which will be held in Orlando, Florida, this year on November 3-6, 1994. Last year, exhibits from Harford, Frederick, and Washington counties were brought to the annual meeting in New Orleans.

The postal plate commemorating Doctors' Day that is now used in 17 states and by the AMA was developed and designed by the Med Chi Auxiliary in 1988 under the auspices of Mildred Taylor, a past Med Chi Auxiliary president who is now serving as SMAA president.

Serving on the SMAA board this year are the following members of the Med Chi Auxiliary: Josie Figueroa, councilor for Doctors' Day; Mary Skipton, councilor for medical heritage; Myrna Goodman, councilor for health education; Betty Molz, Bylaws Committee; Helen Boyer, chairperson, Finance Committee; Bea Sadowsky, Health Education Committee; Bobbie Niklewski, chairperson, Long-Range Planning Committee; Ching Barretto, chairperson, International Liaison Committee; Dr. Reynaldo Lee-Llacer, member of the International Liaison Committee; and Ginny Levickas, Vivian Lynn; and Maragaret Yow, special assistants to the president

CHING BARRETTO

Ms. Barretto is a past president of the Med Chi Auxiliary and immediate past councilor of the SMA Auxiliary ■

President Clinton's health system reform plan: is this what we want?

On January 31, Georgia Lizas, president of the Med Chi Auxiliary, was a panelist at a health care forum sponsored by Congressperson Roscoe Bartlett (R-MD) in Frederick County. The following are the remarks she make about the pitfalls she sees in socialized medicine systems.

I am speaking to you today as a wife, mother, and concerned citizen of this great country. The Clinton health system reform plan has many good proposals and many that disturb me. To me, the plan sounds like a first cousin to Europe's socialized medicine system, and that is what I would hate to see happen in the United States. Let me share with you some of my experiences.

My husband completed a residency in England, which has a socialized medicine system. Doctors in England take their time. Why should they work hard when they will make the same amount of money if they work hard or not? For example, the operating room opens at 9:00 a.m. After the operation, the doctors take a coffee break. They perform another operation and then have lunch. They might do a third case and then have tea. After tea, they see patients at the clinic for an hour and then call it a day. If a patient was at the end of the line, he or she had to come back the next day and wait in line again. Patients have no choice of physician. They see the next available physician. *Is this what we want?*

In another country that I know of, if you don't give the doctor's secretary an envelope filled with money, it might be months before you get the operation you need. If you were fortunate to have the operation, it would probably be an intern or a resident who performed it. You probably would not see the physician after the operation unless that envelope was given to the physician's secretary. *Is this what we want?*

I am also afraid that the quality of medical care will go down. Recently, a patient from Europe came to the United States and went to the Johns Hopkins Hospital. He had an MRI (magnetic resonance image) in Europe, and the European doctors told him that he had Parkinson's disease. One look at the MRI by a doctor at Johns Hopkins told the doctor that the patient had a brain tumor. The patient was operated on and returned home healthy. If he had stayed in Europe, the doctors would probably still be treating him for Parkinson's disease. *Is this what we want?*

My husband recently attended a medical meeting in Paris which was attended mostly by doctors who were

not from the United States. The highlight of the meeting was a surgery shown via satellite from a Boston, Massachusetts, hospital. The doctors who were not from the United States were amazed by all the high tech equipment used in the procedure. However, every piece of that high tech equipment is standard at Frederick Memorial Hospital. Only the wealthiest in Europe can afford to cross the ocean to receive such specialized care, but everyone living in rural Frederick County has access to that same fine care.

There are those who say that the individuals drafting the Clinton plan are aware of the pitfalls and will not let these things happen in the United States. But the type of health care system President Clinton is proposing is so much like socialized medicine that we should all be concerned. People come to America for medical care from all over the world because the United States has the best health care in the world. I would like to keep it that way. From what I have seen, socialized medicine means a reduction in services, a reduction in medical quality, and a reduction in medical technology. *This is definitely not what we want.*

GEORGIA LIZAS

Ms. Lizas is president of the Med Chi Auxiliary ■

MARYLAND

*The Auxiliary
always welcomes
new members.*

*Auxiliary members support
the physicians and are
recognized for their contri-
butions to health, education,
and the promotion of quality
health care in Maryland.*

For information on becoming a
member, call JoAnn Troisi at
Med Chi's Auxiliary office.

539-0872 (Baltimore area)
1-800-492-1056 (toll free in MD)



WELCOME!

The Medical and Chirurgical Faculty of Maryland welcomes the new members listed below. They join an organization with a 195-year history of dedicated service to improving the health and welfare of the people of Maryland. With the help and expertise of longtime members and the participation and input of new members, Med Chi can continue its proud tradition of ensuring quality health care.

ALLEGANY COUNTY

Chaney, Charles R.
363 S. Cleveland Avenue
Hagerstown, MD 21740
301-791-4866
GS

Rickel, Ralph, Jr.
P.O. Box 70
Pinto, MD 21556
301-729-3726
FP; SS 060

ANNE ARUNDEL COUNTY

Gummerson, Kenneth S.
Anne Arundel Medical Center
Franklin & Cathedral Streets
Annapolis, MD 21401
410-267-1290
EM; BC 016; SS 285

Krieger, Susan H.
2772 Rutland Road
Davidsonville, MD 21035
410-798-1600
PD; SS 132

Nakamoto, Rona K.
P.O. Box 403
Millersville, MD 21108
410-760-0033
AN; SS 430,636,881

BALTIMORE COUNTY

Amin, Farid B.
6701 N. Charles Street
Baltimore, MD 21204
410-296-4616
AN; BC 005

Cook, Joseph W., IV
516 N. Rolling Road
Catonsville, MD 21228
410-744-8822
IM; SS 312

Fine, Eric M.
#1 Investment Place
Towson, MD 21204
410-887-3422
PD; BC 055

Fowler, Paul B.
Russell Morgan Prof. Bldg.
5601 Loch Raven Boulevard
Baltimore, MD 21239
410-532-5258
RO; SS 675

Ginsberg, Ronald L.
Suite 302
19 Walker Avenue
Baltimore, MD 21208
410-484-4840
GE,IM; BC 203,020; SS 312

Grossman, Larry B.
Dept. of Anesthesiology
Northwest Hospital Center
5401 Old Court Road
Randallstown, MD 21133
410-521-2200
AN; BC 005; SS 636,881

Ho, Yung-Chieh
6701 N. Charles Street
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410-828-2203
AN; SS 636

Jewell, Kay E.
6325 Security Boulevard
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410-966-4657
IM,GER; BC 020

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ON,IM; SS 654

Roat, Melvin I.
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410-655-8114
OPH; BC 035; SS 115

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ORS; BC 040

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RHU,IM; BC 020,209

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OBG; SS 300

MONTGOMERY COUNTY

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FP; BC 018; SS 060

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P; BC 075; SS 516

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D; BC 015

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RESIDENT COMPONENT

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410-265-1287
N

PRACTICE ISSUES

MEDICARE MEDICAL POLICIES

Drugs and biologicals

- ☐ Subject: Allergen immunotherapy
- ☐ Effective date: 1989
- ☐ Revised date: January 1, 1994
- ☐ CPT (current procedural terminology) and HCPCS (Health Care Financing Administration common procedural coding system) code(s): 95115–95199

■ Description of service

Immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage that is maintained as maintenance therapy.

■ Clinical indications

Allergen immunotherapy will be payable for the following diagnoses

- | | |
|--------|--|
| 372 | Disorders of conjunctiva |
| 381 | Non-suppurative otitis media and eustachian tube disorders |
| 466 | Acute bronchitis and bronchiolitis |
| 471.9 | Unspecified nasal polyp |
| 472.0 | Chronic rhinitis |
| 473 | Chronic sinusitis |
| 474.12 | Chronic disease of adenoids |
| 477 | Allergic rhinitis |
| 477.0 | Allergic rhinitis due to pollen |
| 477.8 | Allergic rhinitis due to other allergen |
| 493 | Asthma |
| 691.8 | Other atopic dermatitis and related conditions |
| 692.9 | Contact dermatitis and other eczema, unspecified cause |
| 693.1 | Dermatitis due to food |
| 708.0 | Urticaria |
| 784.0 | Symptoms involving head and neck |
| 786.2 | Cough |
| 989.5 | Toxic effect of venom |
| 995.0 | Anaphylactic shock |
| 995.1 | Angioneurotic edema |

Allergen immunotherapy not including extracts (CPT 95115, 95117)

CPT codes 95115 and 95117 describe administration of allergenic extracts when the extract is not included in

the code descriptor. An example of this might be when a patient brings his or her allergenic extract (e.g., multiple-dose vial) that was provided by an allergist to a family practitioner who administers a single injection. The family practitioner would report CPT 95115.

A second example would be when the allergist has previously prepared (and reported as CPT 95155) two multiple-dose vials that are retained at the allergist's office. The patient presents on a weekly basis for two injections that are drawn from the multiple-dose vials. When the patient receives two injections, the allergist would code 95117 (one time).

Allergen immunotherapy in prescribing physician's office (CPT 95120–95134)

Codes 95120 and 95125 describe the entire service of preparing and providing the allergenic extract and its administration at a single patient encounter. Similarly, codes 95130–95134 describe the provision of stinging insect venom and its administration, at a single patient encounter. These procedures, with the exception of CPT 95125, represent single-dose vials or single-injection procedures. CPT 95125 should be reported when multiple antigens are provided, prepared, and administered in one or more injections. Report the number of injections as 001, 002, etc.

Provision of antigens (allergenic extracts) (CPT 95144–95170)

This series of codes describes the preparation of antigens including stinging insect venom multiple-dose vials (CPT 95145–95149) and other antigens, single-dose vials (CPT 95144) and multiple-dose vials (CPT 95165, 95170). These codes do **not** include the administration of the antigen. Single-dose vials are those vials that contain a single dose of antigen that is administered in one injection. Multiple-dose vials contain a larger volume of antigen, and doses are administered from the multiple-dose vial at several subsequent visits.

Office visits in conjunction with allergen immunotherapy

An office visit may be reported in addition to allergen immunotherapy only when significant identifiable other services are provided in conjunction with the immunotherapy. This would include such services as examination of the patient, interval history, and evaluation of diagnostic studies.

If allergen immunotherapy is the only service provided, no office visit code should be reported.

PRACTICE ISSUES

Allergen immunotherapy codes 95115 and 95117 are paid separately under the fee schedule if billed with no antigens or if billed with CPT 95144–95170. They cannot be paid if billed with CPT 95120–95134 since those codes include the injection as well as the antigen. Allergen immunotherapy codes 95120–95180 are not paid under the fee schedule because they describe antigens, in whole or in part. Antigens are not included in the statute's definition of "physician services" for fee schedule payment. These codes continue to be paid based upon reasonable charges.

■ Billing and processing instructions

The following guidelines should be used to process claims reporting antigen or venom immunotherapy:

1. CPT 95115–95117 should be used to process claims for **allergy injection only**. Code 95117 is **not** to be reported per injection.
2. CPT 95120–95134 should be used to process claims for the antigen or venom and represents total immunotherapy **including preparation, provision, and injection**.
3. CPT 95144 should be used to process claims only for the **preparation and provision** of an antigen or venom by a physician who may or may not be providing the actual immunotherapy injection.
4. CPT 95145–95149 are for making and providing multiple-dose vials and can be used by both physicians and labs when multiple-dose vials are being supplied. A maximum of six months' supply of venom will be allowed at one time due to shelf-life expectancy. When billing CPT 95145–95149, the number of treatments or total volume should be specified.
5. CPT 95165–95170 are for making and providing multiple-dose vials and can also be used by both physicians and labs. Antigens are limited to a 12-week supply based on Section 2050.5 of the *Medicare Carriers Manual*. When billing CPT 95150–95170, the following should be specified on the claim:
 - a. the number of treatments (in the days or units column), and
 - b. the charge for each treatment, and
 - c. the number of doses it is anticipated will be given each week, (e.g., two times a week). For EMC claims, this information should be shown in the narrative field or free-form comment field. On paper claims, this should be shown in Section 24D of the claim form.

- d. The claim form must document the route of administration.
6. The diagnosis must be appropriate, requiring medication by subcutaneous or intramuscular injection. (Self-administered injections and the sublingual route of administration are not covered.)
 7. The allergy extract must be FDA (Food and Drug Administration) approved and used for indications specified on the labeling.
 8. Postage for mailing of the extract is not covered.

■ Coding changes

Note: Procedure codes 95135, 95140, 95150, and 95155 have been deleted in the 1994 CPT edition. These procedure codes will continue to be valid for 1993 services when billed prior to April 1, 1994.

In addition, procedure codes 95120, 95125, 95145, and 95170 have important verbiage changes.

Procedure code 95144 and 95165 are new CPT codes effective January 1, 1994.

Approved by: Barry S. Gold, M.D., F.A.C.P., Medical Director

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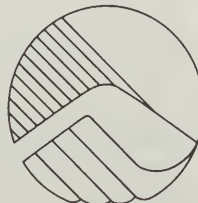
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The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

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- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

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1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

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Checklist

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- ☐ Everything double-spaced.
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of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

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Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

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| Domestic violence | Feb. 10 |
| Sorting it all out | Feb. 17 |
| Tumor conference | Feb. 24 |
| Tumor conference | Mar. 10 |
| Comprehensive evaluation and management of sinus disease | Mar. 17 |
| Update on colon cancer | Mar. 24 |
| Migraines: new treatments, differential diagnosis of headaches | Mar. 31 |

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

| | |
|--|------------|
| Diagnosis and treatment of neoplastic disorders. 14.5 Cat 1 AMA/PRA credits. Fee: \$325 physicians; \$150 residents, fellows, and allied health professionals. | Apr. 7-8 |
| Clinical care of the patient with HIV infection. 13 Cat 1 AMA/PRA credits; 12.75 AAFP credits. Fee: \$325 physicians; \$165 residents, fellows, and allied health professionals. | Apr. 7-8 |
| 21st annual pediatric trends. 41 Cat 1 AMA/PRA credits. Fee: \$650 physicians; \$450 residents and fellows. | Apr. 11-16 |
| Basic concepts in dysphagia diagnosis and management. Cat 1 AMA/PRA credits available. Fee: \$175 physicians; \$100 residents and allied health professionals. | Apr. 13 |
| Fifth multidisciplinary symposium on dysphagia. Cat 1 AMA/PRA credits available. Fee: \$400 physicians; \$225 residents and allied health professionals. | Apr. 14-15 |
| Biological response to orthopaedic implants. 12 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$125 residents and fellows. | Apr. 15-16 |
| Second symposium on the prevention of developmental disabilities in infants and toddlers. 14 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. | Apr. 18-19 |
| International conference on crystalline silica health effects: current state-of-the-art. Fee: \$450. | Apr. 18-20 |
| 35th annual postgraduate institute for pathologists in clinical cytopathology. Course A (home study). Preparation for Course B. | Mar.-Apr. |
| 35th annual postgraduate institute for pathologists in clinical cytopathology. Course B. 136 Cat 1 AMA/PRA credits. | Apr. 18-29 |
| Pediatric allergy and immunology for the practitioner. Cat 1 AMA/PRA credits available. Fee: TBA. | May 5-6 |
| Phototherapy and photochemotherapy. 10 Cat 1 AMA/PRA credits. Fee: \$250 physicians; \$200 nurses and technicians; \$150 residents and fellows. | May 6-7 |
| Optional strategies for treating peripheral vascular disease: a debate. Cat 1 AMA/PRA credits available. Fee: \$25. | May 7 |

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| 21st century retina: what's hot, hype, and hard fact. 8 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$100 residents, fellows, and allied health professionals. | June 10 |
| Principles and practices of data management for clinical trials. Cat 1 AMA/PRA credits available. Fee: TBA. | June 16-17 |
| Advanced pediatric life support courses. 20 Cat 1 AMA/PRA credits; 18.5 AAFP prescribed hours; 20 AAP credit hours; 17 ACEP Cat 1 credits. Fee: \$525. | June 13-15 |
| Airway management: hands on workshops, case management colloquia, and difficult airway/intubation alert. Cat 1 AMA/PRA credits available. Fee: \$650. | Sept. 23-25 |
| Annual topics in gastroenterology and liver disease. Cat 1 AMA/PRA credits available. Fee: \$495 physicians; \$250 residents and fellows (with letter from department chairperson verifying status). | Oct. 5-7 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27-30 |

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Johns Hopkins sports medicine grand rounds.** Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- R. Adams Cowley 16th annual national trauma symposium,** at the Hyatt Regency, in Baltimore, Maryland. Info: 410-328-2399. **Nov. 16-20**

Miscellaneous meetings

- Ultrasound in abdominal surgery,** at the George Washington University Medical Center, in Washington, DC. 8 Cat 1 AMA/PRA credits. Fee: \$495. Info: Maria Gorricks, 202-994-1791. **Mar. 18**

Miscellaneous meetings (continued)

| | |
|---|-------------------|
| Echocardiography for the sonographer , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | Mar. 24–26 |
| Advanced catheter and surgical ablation for arrhythmias , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 6–8 |
| Monumental City Medical Society round table discussion , at Liberty Medical Center, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-652-0022. | Apr. 7 |
| Frontiers in ovulation induction , sponsored by the Washington University School of Medicine, in Philadelphia, Pennsylvania. Info: 800-325-9862. | Apr. 8 |
| Cardiac Pacing , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 11–14 |
| Echo/Doppler applications in coronary artery disease with emphasis on exercise and pharmacological stress echo , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 18–19 |
| Transesophageal echocardiography: demonstration of technique, image orientation, and interpretation of single, biplane, and mutliplane TEE , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 20–22 |
| Clinical psychopharmacology: review and update—1994 , at the Sheppard Pratt Conference Center, in Baltimore, Maryland. 6.25 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. | Apr. 22–23 |
| Nuclear cardiology for the technologist , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 25–27 |
| "Doctor I can't sleep"—a course on insomnia , sponsored by Georgetown University Hospital Sleep Disorders Center, in Washington, DC. 3 Cat 1 AMA/PRA credits. Fee: \$35. Info: Reid C. Blank, 310-288-0466. | Apr. 28 |
| Recent advances in clinical nuclear cardiology , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 28–30 |
| Federation of state medical boards annual meeting , sponsored by the George Washington University Medical Center, at the Grand Hyatt, in Washington, DC. Info: Maria Gorrick, 202-994-4285. | Apr. 28–30 |
| Challenge of improving health care in the city , sponsored by the Baltimore City Medical Society, at James Lawrence Kernan Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-625-0022. | May 5 |
| 46th annual meeting and scientific session , sponsored by the Maryland Academy of Family Physicians, in Ocean City, Maryland. 41.25 Cat 1 AMA/PRA credits; 41.25 AAFP prescribed hours. Fee: \$240 members; \$275 nonmembers; \$135 paramedicals; free for residents, medical students, MAFP retired and life members. Info: Richard Colgan, M.D., 410-747-1980. | May 10–15 |
| Clinical auscultation of the heart , sponsored by the American College of Cardiology, at the Georgetown University Medical Center, in Washington DC. 18 Cat 1 AMA/PRA credits. Info: 301-897-2695. | May 11–13 |

Miscellaneous meetings (continued)

- Medical and Chirurgical Faculty of Maryland's Annual Meeting** at the Ramada Inn and Convention Center, in Hagerstown, Maryland. 14 Cat 1 AMA/PRA credits. Fee: Free for Med Chi members. Info: Joan Mannion, 410-539-0872 or 800-492-1056. **May 12-14**
- Modern advances in the treatment of pain**, sponsored by the Baltimore City Medical Society, at St. Agnes Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: free. Info: 410-625-0022. **June 2**
- Obstetrics dilemmas in the era of managed health care**, sponsored by the Eastern Virginia Medical School, at the Sheraton Inn Oceanfront, in Virginia Beach, Virginia. Cat 1 AMA/PRA credits available. Info: Jeanette Schmitz, 804-446-6143. **June 3-4**
- Board review in family medicine**, sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, in Arlington, Virginia. Info: Daniel Reichard, 202-994-4285. **June 11-15**
- Twelfth summer symposium in internal medicine**, sponsored by the Eastern Virginia Medical School, at the Holiday Day on the Ocean, Virginia Beach, Virginia. 15.5 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$195 resident, nurse, allied health. Info: Ann McClanahan, 804-446-6141. **June 24-26**
- Psycho-economics: clinical psychiatry and health care reform in the 1990s**, sponsored by the American Psychiatric Association, in Baltimore, Maryland. 34 Cat 1 AMA/PRA credits. Info: 202-682-6174. **Oct. 8-11**

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month; 8:00-9:00 am. Fee: none. Info: R. Classon, 410-337-4500.



PHYSICIAN'S RECOGNITION AWARD

During January 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

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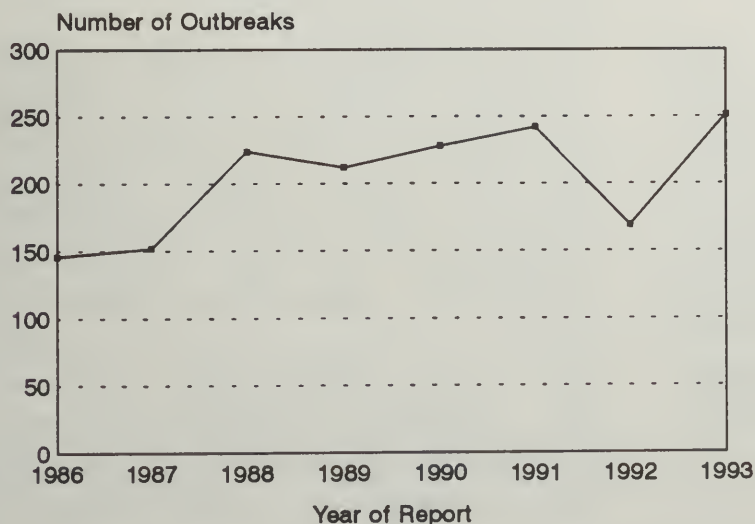
February, 1994

Outbreaks of Communicable Diseases Reported in 1993 to the Maryland Department of Health and Mental Hygiene

In this article, information pertaining to communicable disease outbreaks reported in 1993 and the steps involved in outbreak investigation will be presented. Additionally, summaries of selected outbreaks investigated during 1993 are being provided.

During 1993, 251 outbreaks of acute communicable diseases were reported to the Maryland Department of Health and Mental Hygiene (DHMH). Figure 1 shows the trend in outbreak reporting from 1986 to 1993. The highest number of outbreaks during this eight

Figure 1. Communicable Disease Outbreaks Reported to the Maryland Department of Health & Mental Hygiene, 1986-1993



year period was reported in 1993. The number of outbreaks reported to DHMH in any given year is greatly influenced by the number of nursing homes reporting outbreaks. Approximately 50 percent of all reported outbreaks are from nursing homes, primarily due to viral gastroenteritis and confirmed or suspected influenza. Table 1 depicts the types of illness according to the site of occurrence for each outbreak.

Summaries of Selected Outbreaks

Multistate Outbreak of Oyster Related Gastroenteritis: the Maryland Experience

On November 17, 1993, three outbreaks of gastroenteritis were reported among patrons who attended events where raw oysters were consumed. Reports of illness following two similar events soon followed. In all, over 89 individuals across the state were found to have had symptoms of nausea, vomiting and diarrhea within 72 hours of exposure. Communication with Centers for Disease Control and Prevention (CDC) revealed simultaneous events in Louisiana and Mississippi, and subsequently North Carolina and Florida, suggesting a common source of contaminated raw oysters in the shell. The implicated oysters were traced back to the Grand Pass and Cabbage Reef harvest areas off the Louisiana coast by their shipment tags and invoices. To avoid further illness, the implicated harvest beds were closed, a recall of all oysters harvested from the region prior to its closure was undertaken, and a press release was issued to alert consumers.

In these Maryland outbreaks, stool and serum specimens sent to CDC identified the cause of illness as a type of Norwalk virus. CDC is now testing a promising new polymerase chain reaction (PCR) technique for identifying Norwalk viruses in addition to the previously used the technique of electron microscopy (EM).

Fortunately, shellfish related viral gastroenteritis is a self-limited illness for most individuals. However, the risk for severe and even fatal disease is significant in those with chronic health problems (hepatic or gastrointestinal disease, diabetes, alcoholism, cancer, kidney or hematologic disorders) or in patients who are immunocompromised. Patients with any of these conditions should be warned of the dangers of raw shellfish consumption.

Outbreak of Hepatitis A on the Eastern Shore

In late December, 1994, an outbreak of hepatitis A was identified on the lower Eastern Shore (Wicomico County, Maryland and Sussex County, Delaware). Two early cases with onset dates in November 1993 were followed by at least 13 subsequent cases with onsets between December 5, 1993 and January 1, 1994. Two asymptomatic cases in children with contact to the early cases were also identified.

Outbreak investigation revealed that one of the cases with onset of illness in November had worked as a foodhandler at a restaurant in November. The foodhandler case had symptoms, but never saw a physician and was not diagnosed until mid-January during the investigation. Eleven of the 13 December and January cases were patrons at the restaurant and most likely contracted it from eating uncooked foods handled by the infected foodhandler. Fortunately, no other workers at the restaurant contracted hepatitis; all were IgM negative and asymptomatic approximately six weeks after their last exposure to the index case. Immune globulin (IG) was not recommended to patrons at the time the outbreak was recognized because there was no evidence that the restaurant presented an on-going risk to the public.

At least one secondary case has been reported among household contacts who refused administration of IG.

Although hepatitis A is most commonly spread person-to-person, national surveillance data suggests that three to eight percent of cases occur through foodborne or waterborne outbreaks. These usually result from either contamination of food (usually cold sandwiches or salads) by an infected food handler or by primary contamination of food itself (usually shellfish from contaminated beds). Although investigation after an outbreak begins can often reveal the original source of infection, it is early investigation at

the time of individual diagnosis that can best prevent further spread of disease. There are several steps that health care providers can undertake when a case is first identified:

1. Clarify whether the individual is at high risk of spreading hepatitis to others (food-handlers, health care workers, day care center staff, or those who work with the elderly). Virus will continue to be shed for approximately one week after onset of jaundice or two weeks after illness onset if not jaundiced. Individuals should be excluded from these jobs during that time.
2. Generate a list of household or other close contacts (names and phone numbers). This is especially crucial when patients present to emergency rooms or urgent care centers where patient phone numbers and addresses given may not always be reliable for tracking patients later.

During the outbreak on the Eastern Shore, one early case was seen in an emergency room. Because the case left the area before the health department received notification, there were no leads upon which interviewing and contact tracing could be done. Had the local health department been able to talk to contacts, it is probable that the infected food-handler who was a family member of the case could have been identified.

3. Call the Communicable Disease section of your local health department to report a case of hepatitis. By Maryland law, hepatitis A is to be reported within 48 hours of diagnosis. An early start on interviewing, contact tracing, and administration of IG to all who were exposed in the past two weeks can dramatically reduce continued spread of the disease.

Tuberculosis in a College Student

As part of an investigation into the source of tuberculosis (TB) in four children, a case of cavitary and laryngeal TB was identified in a

student attending a university in Maryland. The source case reported symptoms for at least nine months, five of which while attending the university. During that time, the case also received prenatal care and gave birth to a child. The investigation focused on the identification of persons with TB disease or TB infection by screening at the university. TB skin tests and a self-administered questionnaire were used; a chest X-ray and interview were obtained for persons with a positive tuberculin test, defined as ≥ 5 mm in duration. Medical and laboratory records were reviewed for persons with suspected TB. Isolates of *Mycobacterium tuberculosis* were sent to the CDC for restriction fragment length polymorphism (RFLP) analysis.

Results of the investigation identified six college students with active TB in addition to the four previously identified children. Of the four available isolates tested by RFLP, all were identical to that of the source case. Preliminary results of tuberculin testing at the university are available for 1746 students. Excluding the foreign born, contacts were significantly more likely to have a positive skin test than non-contacts (82/403 (20.3%) vs. 41/1168 (3.5%) OR = 6.97, 95% Confidence Interval: 4.62 - 10.55). At least 25 contacts had a documented skin test conversion (≥ 10 mm increase in duration) within the past year. On the average, classmates with a positive skin test had twice as many class hours with the source patient as did classmates with a negative test (63 vs 33 hours, $p < 0.01$). In summary, at least 10 persons with active TB and 25 persons with skin test conversions have been identified as being epidemiologically linked to the source patient. Timely diagnosis of this patient during medical care during her pregnancy may have prevented subsequent cases and infections.

Outbreak Investigations and Reporting

The reporting of outbreaks is mandated by the Code of Maryland Regulations 10.06.01 Communicable Diseases which require

physicians and other health care providers, school and child care facility personnel, and food establishments to report outbreaks in addition to selected communicable diseases. Prompt reporting is critical for early intervention and control of outbreaks.

Once reported, the investigation of an outbreak involves several steps which may be performed by the local and/or state health department investigators. The steps include: verify the diagnosis; establish that an outbreak exists; interview exposed persons (ill and well); obtain clinical specimens and environmental specimens such as food or water, when appropriate; perform data analysis with inter-

pretation of results; implement control measures; and report the findings. The ultimate goal of outbreak investigation is the prevention of further illness and the protection of the public's health.

1. CDC. Foodborne Hepatitis A--Missouri, Wisconsin, and Alaska, 1990-1992. MMWR 1993; 42(27) pp. 526-529.

2. Code of Maryland Regulations, 10.06.01.04B Communicable Diseases.

Table 1: Reported Outbreaks by Site of Occurrence, in Maryland, 1993

| Type of Outbreak | Site of Occurrence | | | | | | | |
|---|--------------------|--------------|----------|-------------|--------------|--------|-------|-------|
| | Day Care | Food Service | Hospital | Institution | Nursing Home | School | Other | Total |
| Conjunctivitis | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 3 |
| Gastroenteritis: viral, chemical, or undetermined | 0 | 38 | 1 | 2 | 43 | 1 | 11 | 96 |
| Giardia | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 3 |
| Influenza: confirmed or suspected | 0 | 0 | 0 | 0 | 79 | 0 | 0 | 79 |
| Norwalk | 0 | 3 | 0 | 0 | 0 | 0 | 2 | 5 |
| Salmonella | 0 | 3 | 0 | 1 | 1 | 0 | 5 | 10 |
| Scabies | 0 | 0 | 0 | 2 | 8 | 1 | 0 | 11 |
| Scombroid poisoning | 0 | 4 | 0 | 0 | 0 | 0 | 1 | 5 |
| Shigella | 6 | 0 | 0 | 2 | 0 | 0 | 1 | 9 |
| Tuberculosis** | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 4 |
| Other* | 2 | 2 | 2 | 2 | 9 | 4 | 5 | 26 |
| Total | 8 | 51 | 4 | 10 | 142 | 9 | 27 | 251 |

*Other refers to outbreaks of boils (1), botulism (1), ciguatera fish poisoning (1), febrile illness (1), *Haemophilus influenza* disease (2), hemolytic uremic syndrome (1), hepatitis (1), meningitis (1), methicillin-resistant *Staphylococcus aureus* infections (2), pertussis (1), pneumonia/bronchitis (1), rash illness (1), ringworm (1), septicemia (1), strep throat (1), trichinosis (1), upper respiratory illness (7), vancomycin-resistant *Enterococcus* infections (1).

**The four outbreaks of tuberculosis include two PPD conversions, one psuedo-outbreak, and one school-based outbreak.

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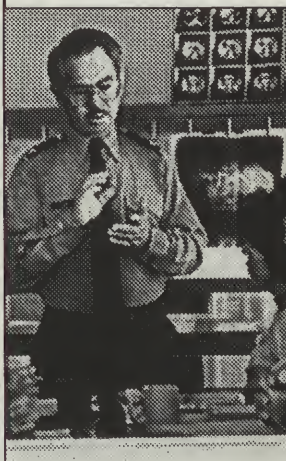
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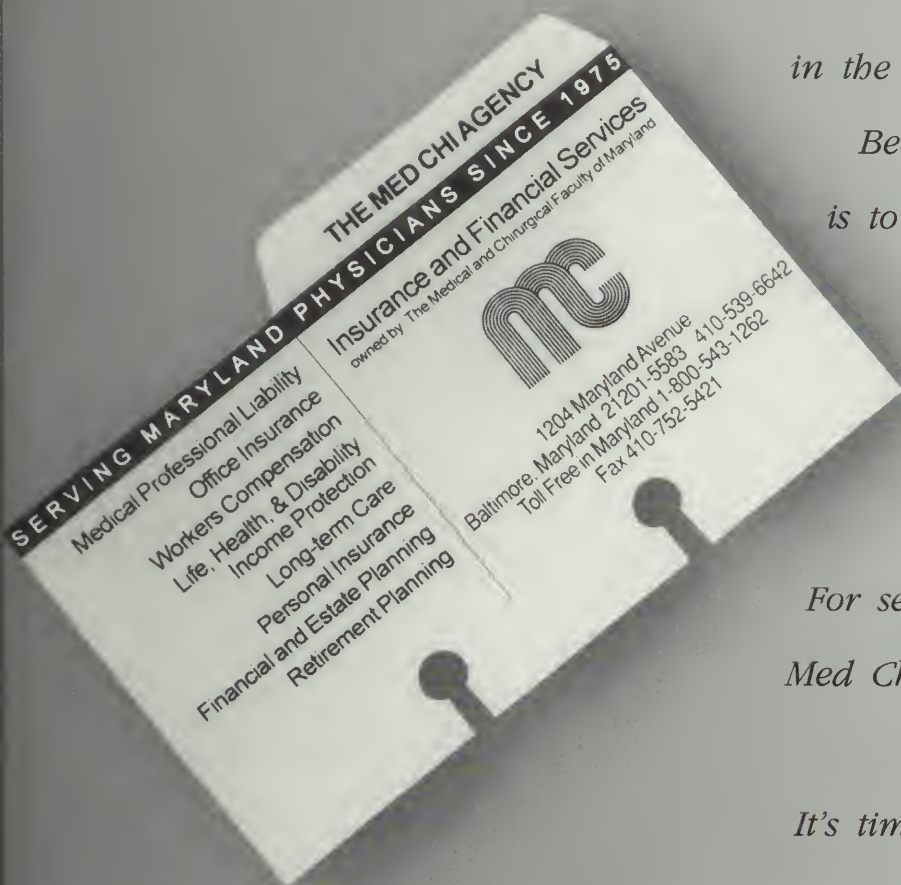
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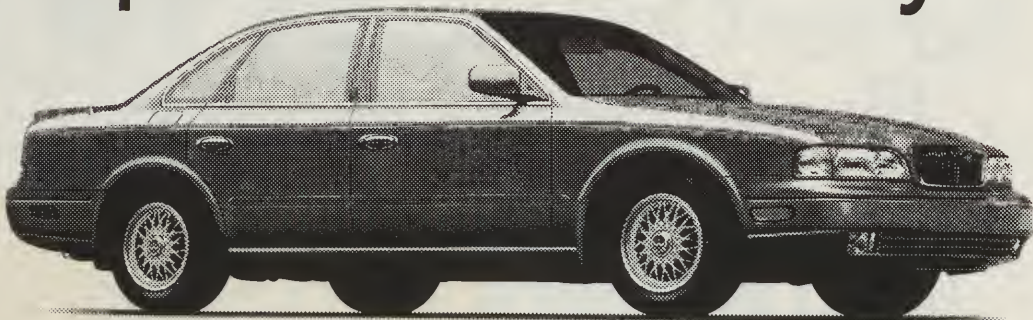
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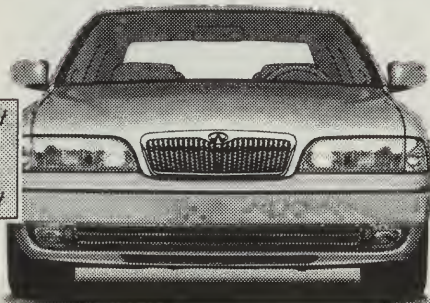
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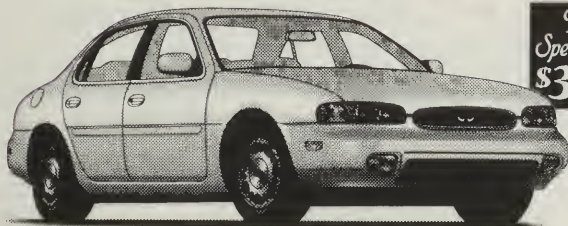


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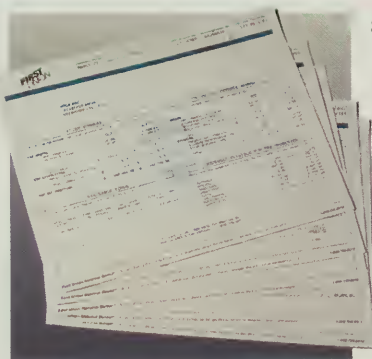
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First Union is the only bank that offers the CAP Account. To find out more, stop by any branch, or call us at 1-800-733-8812. We'll point you in the right direction.

FIRST UNION®

First Union National BanksSM

When it comes to service, everything matters.®

Banking offices in Florida, Georgia, Maryland, North Carolina, South Carolina, Tennessee, Virginia and Washington, D.C. ©1994 First Union Corporation Member FDIC *\$15,000 minimum deposit in cash or securities to open the CAP Account. First year's annual fee waived if account is opened by May 31, 1994. Brokerage services are provided by First Union Brokerage Services, Inc. (Member NASD/SIPC).

Chief Executive Officer's Newsletter

March 1994

Preliminary Program and Hotel Reservations for the Annual Meeting (May 12 - 14, 1994)

The preliminary program for the 196th Annual Meeting of the Medical and Chirurgical Faculty of Maryland, "Medicine Under Health System Reform — Impact on Patients and Physicians," immediately follows this issue of the *Chief Executive Officer's Newsletter*. Please note, when making reservations for overnight accommodations at the Ramada, you must use the local number, 301-733-5100, and indicate that you are attending the Med Chi meeting. The 800-number previously listed in the preliminary program is the national reservation line, and does not reflect rooms available in the Med Chi room block; therefore, people calling the 800-number will be told no rooms are available.

MMPAC Will Hold Luncheon at Med Chi Annual Meeting (May 14, 1994)

Maryland Medical Political Action Committee (MMPAC) will hold a luncheon on Saturday, May 14, 1994, 12:30 pm to 2:00 pm, in conjunction with the Med Chi annual meeting at the Ramada. American Medical Political Action Committee board member, William Alexander, M.D., will be the speaker. MMPAC members may attend the luncheon at no charge and non-MMPAC members may attend at cost (to be determined), or may join MMPAC. Reservations are required — call Debbie Sciabarrasi at 410-539-0872 or 1-800-492-1056, ext. 303, no later than May 6.

Health Care Antitrust Improvements Act

The Health Care Antitrust Improvements Act of 1993 was introduced as H.R. 3486 by Representative Bill Archer. This act would represent an important first step toward balancing the market power of the large insurers and managed care plans with the ability of physicians to advocate for their patients. The legislation would create "safe harbors" exempting certain activities from the antitrust laws. The exempt activities would in no way open the door to such antitrust violations as price-fixing and group boycotts. The seven safe harbors defined in the legislation are:

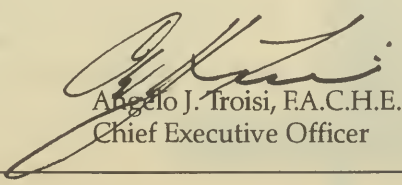
1. collective activities related to the provision of health care services in which the number of each type of provider or specialty does not exceed 25% of the market;
2. activities of medical self-regulatory entities (e.g., peer review);
3. joint participation in cost or price surveys to be used with third party payers;
4. joint ventures for high-tech, high-cost equipment and services;
5. hospital mergers;
6. joint purchasing arrangements representing less than 35% of sales in the relevant market; and
7. negotiations to carry out any activity protected as a safe harbor.

Additionally, health care cooperative ventures that meet specific size and financial risk-sharing requirements would be permitted to be formed. The formation of such ventures would create expanded choices and greater options for patients in obtaining access to health care.

Physicians are encouraged to lend support to this antitrust legislation by writing to their United States Representatives.


Update on Independent Practice Associations (IPAs)

For a status report on the Med Chi physician organization efforts, please see the letter from Allan D. Jensen, M.D., Chairperson, Ad Hoc Committee for Establishing an IPA, which immediately follows this issue of the *Chief Executive Officer's Newsletter*.


Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

INDEPENDENT PRACTICE ASSOCIATIONS

MEMORANDUM

TO: All members
FROM: Allan D. Jensen, M.D. 
Chairperson, Ad Hoc Committee for Establishing an IPA
DATE: April 1994
RE: Update on Independent Practice Associations

Over the past few months, Med Chi has been listening carefully to you, physicians of Maryland, about the challenges of the private practice of medicine. From your calls and letters, we know that managed care is a primary concern. There's a furious pace of strategic alliances being formed between providers and payors in anticipation of federal and state health reform. The speed of market reform and consolidation is confusing to even the most seasoned observers.

Another meaningful subject to our physicians is office practice management. A number of outside companies are canvassing Maryland, offering to buy or manage successful physician practices. Some area hospitals are buying physician practices, or establishing physician office management subsidiaries. Hospitals see this entry into ambulatory services as an advantageous integration strategy.

The cataclysmic changes in health care create significant new opportunities for physicians. In response, physicians all over Maryland are organizing Independent Practice Associations (IPAs), Management Services Organizations (MSOs) and similar organizations.

Med Chi is working hard to determine the best way to help our members respond to market challenges. We have retained Eastwest Research Corporation, a consulting firm in Bethesda, to assist Med Chi with the feasibility, design and implementation of our managed care program. Together, we are exploring the following major strategies:

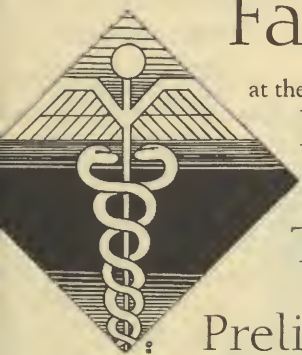
1. **Med Chi sponsorship of a statewide IPA**, which would integrate individual physicians and coordinate with local IPAs where they exist. The statewide IPA would establish managed care relationships on behalf of members, and provide *managed care administrative services* for local IPAs. *Managed care administrative services* include: utilization management, quality assurance and development of critical paths; financial risk management; preprocessing of claims; management reporting; marketing; eligibility verification; credentialing; peer review; and provider relations.
2. **Med Chi sponsorship of a practice management services company**, which would provide consulting and *practice management services* for interested physicians or groups. *Practice management services* include: billing, coding, and accounts receivable management; electronic claims submission; medical records systems; appointment systems; telephone systems; personnel services; building and facilities management; clinical laboratory management; group purchasing; and financial services.

To better understand how Med Chi strategies can complement what is already in the field, our consultant has begun to identify and assess physician-sponsored IPAs, MSOs and other organizations. Eastwest will also talk with many Med Chi physicians, to supplement and focus information gained through recent membership surveys. We ask your cooperation with their efforts.

We see physician empowerment as the next logical step in the reorganization of health care delivery. We believe a Med Chi sponsored statewide organization may successfully represent the interests of physicians in the marketplace of the future.

There will be a report on our progress at the annual meeting in Hagerstown, May 12-14, 1994. We will keep you informed.

196th Annual Meeting of the Medical and Chirurgical Faculty of Maryland



at the

Ramada Inn and Convention Center
Hagerstown, Maryland

Thursday-Saturday, May 12-14, 1994

Preliminary Agenda



Medicine
Under Health
System Reform —
Impact on
Patients and
Physicians



For room reservations at the Ramada,
please call 301-733-5100
and indicate that you will

Continuing Medical Education Credits

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for up to 24.5 hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Physicians attending this year's meeting can earn up to a maximum of 14 CME credits.

Thanks

The Medical and Chirurgical Faculty of Maryland wishes to thank Abbott Laboratories, The Med Chi Agency, Pfizer, Inc., SmithKline Beecham Pharmaceutical and The Upjohn Company for helping to support the annual meeting's continuing medical education program.

Directions

The Ramada Inn and Convention Center is located at 901 Dual Highway (Route 40 West) in Hagerstown, Maryland.

From Baltimore
and points east:

Take I-70 West toward Hagerstown to exit 32B (Route 40 West). After taking exit 32B, proceed approximately 2.5 miles on Route 40. The Ramada Inn and Convention Center will be on your left.

From Montgomery
County, Washington and
points south:

Take 270 North to Frederick. Exit onto I-70 West and take I-70 West to exit 32B (Route 40 West). After taking exit 32B, proceed approximately 2.5 miles on Route 40. The Ramada Inn and Convention Center will be on your left.

From Western Maryland
and points west:

Take I-70 East toward Hagerstown to exit 32B (Route 40 West). After taking exit 32B, proceed approximately 2.5

miles on
Route 40.
The
Ramada
Inn and
Convention
Center will
be on your
left.

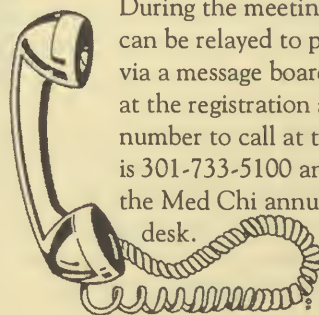


be attending the
Med Chi Annual
Meeting. Room
rates are \$57 for
single or double
occupancy.*
Reservations
must be made by
Friday, April
29, 1994.

*Tax and incidentals not included.

Telephone Messages

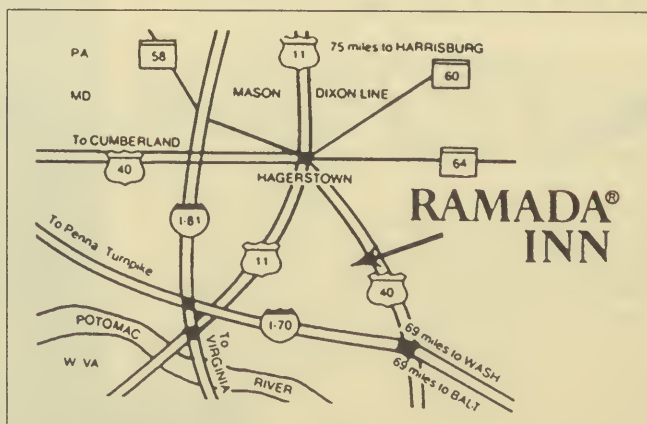
During the meeting, messages can be relayed to participants via a message board located at the registration area. The number to call at the Ramada is 301-733-5100 and ask for the Med Chi annual meeting desk.



Miscellaneous

Questions about continuing medical education sessions? Call Joan Mannion at 1-800-492-1056 or 410-539-0872.

General questions about the annual meeting should be directed to Ruth Seaby or Vivian Smith at 1-800-492-1056 or 410-539-0872.



Support Our Exhibitors

Exhibits are an integral part of the Med Chi Annual Meeting and are a valuable adjunct to the scientific program.

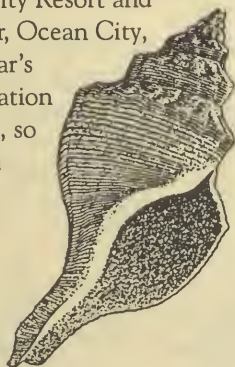
During this year's annual meeting, Med Chi has allocated several special time periods for physicians to meet one-on-one with exhibitors. By visiting exhibits, you will help ensure that Med Chi continues to receive valuable income that allows us to offer you annual and semiannual meetings.

FINANCIAL MED CHI urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.

DRUG MANUFACTURERS

1994 Semiannual Meeting

Plan now to attend the Med Chi 1994 Semiannual Meeting, Friday, September 9 to Sunday, September 11, 1994, at the Sheraton Ocean City Resort and Conference Center, Ocean City, Maryland. Last year's meeting at this location was a great success, so we hope to see you there!



INSURANCE

Special Events

Meal Events

WOMEN IN MEDICINE LUNCHEON **\$10.00**

Thursday, May 12, 1994
1:00 pm - 2:00 pm
Women in Medicine Committee

This luncheon is open to all women physicians and their spouses.

WELCOME RECEPTION SPONSORED BY THE RAMADA INN IN THE BALLROOM

Thursday, May 12, 1994
6:30 pm - 7:30 pm

Relax with your colleagues and enjoy drinks and hors d'oeuvres compliments of the Ramada. Exhibits will be open during this event.

PRAYER BREAKFAST \$6.00

Friday, May 13, 1994, 8:00 am - 9:30 am
Committee on Medicine and Religion

Enjoy a breakfast buffet with like-minded caring physicians while hearing M. Roy Schwarz, M.D. speak on the topic "The Current Imperative for an Ethical Renaissance in Medicine." Problems of ethical misconduct and their impact on physician/patient relationships will be explored. The credibility of physician leadership in biomedical ethical issues will also be discussed.

Dr. Schwarz is senior vice president for medical education and science with the AMA. One CME credit will be awarded to participants.

RECEPTION WITH THE PERCUSSION ENSEMBLE OF THE MARYLAND SYMPHONY ORCHESTRA **NO CHARGE**

Friday, May 13, 1994
6:30 pm - 7:30 pm
Hosted by the Washington County Medical Society.



SUCCESSFUL INVESTMENT STRATEGIES FOR PHYSICIANS **NO CHARGE**

Saturday, May 14, 1994
8:00 am - 9:30 am

This special breakfast meeting is sponsored by *Physician's Practice Digest*. Pre-registration is required for this breakfast meeting.

Marianne Billek-Kuta, investment executive for Ferris, Baker, Watts, Inc. will update physicians on current trends in investment strategies, including the risks and benefits associated with investments in stocks, mutual funds, real estate and art.

No CME credit will be given for this lecture.

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE (MMPAC) LUNCHEON MEETING

Saturday, May 14, 1994, 12:30 pm - 2:00 pm

William Alexander, M.D., of the American Medical Political Action Committee will be speaking.

Registration is required through Debbie Sciabarrasi at 410-539-0872 or 1-800-492-1056. It is free for MMPAC members; non-MMPAC members will be charged an additional fee. The registration deadline is May 6.

PRESIDENTIAL BANQUET \$50.00 honoring Donald H. Dembo, M.D.

Saturday, May 14, 1994, 6:30 pm - 11:00 pm

Featuring: Gene Donati Presentations

As orchestra leaders go, Gene Donati is the scientist - combining personality, reputation, hard work and requiring complete dedication from his musicians. Mr. Donati's orchestra performs frequently in the Washington competitive society-music market, including performances at the White House.



Bus Trips

Saturday, May 14, 1994
9:00 am -3:00 pm

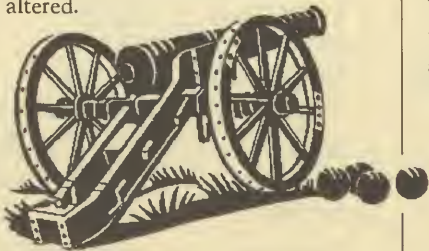
A minimum of 20 participants is needed for these events; if a trip is canceled due to insufficient registration, registrants' money will be refunded. Deadline for registration is April 29, 1994.

CHOICE A - HISTORICAL DAY \$25.00

10:00 am - 12:00 Antietam Battlefield
12:30 pm - 2:00 pm Lunch at the Bavarian Inn

Antietam Battlefield
Sharpsburg, Maryland

The Battle of Antietam (or Sharpsburg) on September 17, 1862, climaxed the first of Confederate General Robert E. Lee's two attempts to carry the war into the North. When the fighting ended that day, "The Bloodiest Day of the Civil War," the course of the American Civil War had been greatly altered.



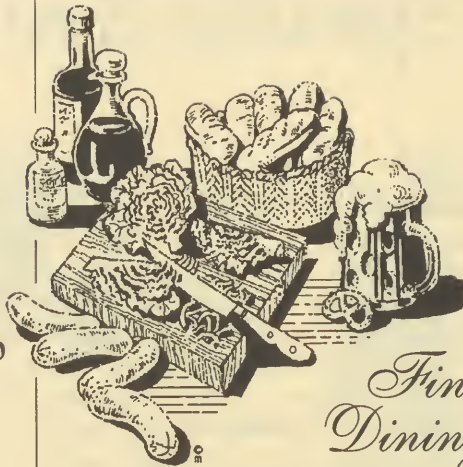
CHOICE B - A DAY AT THE OUTLETS \$9.00

10:00 am -3:00 pm - Shopping at the Martinsburg Outlets

Blue Ridge Outlet Center
Martinsburg, West Virginia

This outlet center, "the authentic manufacturers outlet," is a renovated historic woolen mill dating to the turn of the century. Leading manufacturers of everything from clothing to housewares offer savings of up to 70%. Retailers include:

| | |
|---------------------------|---------------------------|
| Anne Klein | Damon |
| Arrow/Gold Toe | Dan River |
| Banister Shoe | Dansk |
| Barbizon Lingerie | Donna Karan |
| Bass Shoe | Etienne Aigner |
| Book Warehouse | Evan Picone Gant |
| Boston Trader | Factory Linens |
| Brassworks | Famous Brands Housewares |
| Carter's Childrenswear | Five Sisters Gifts |
| Champion Athletic Apparel | Flapdoodles |
| Corning/Revere | Fuller Brush |
| Country Road Australia | Georgetown Leather Design |
| CW Company Store | Gold-N-Silver |



Fine Dining

The Bavarian Inn and Lounge,
Shepherdstown, West Virginia

"Old World Dining and Lodging at its Best"

The Bavarian Inn's award-winning restaurant is located in the Greystone Mansion, located on grassy lawns, overlooking the Potomac River. The dining rooms are bright and elegant, decorated with antiques, beautiful china and deer horn chandeliers. The international cuisine offers a wide variety of German and American specialties.

Office Managers' Afternoon

Friday, May 13, 1994
2:30 pm - 6:00 pm

2:30 pm - 5:00 pm

This special time has been set aside for physician office managers to get a look at the latest in medical office equipment, billing services, automated office management systems, and more. Special drawings will be held in the exhibit hall during this time — win prizes donated by exhibitors and Hagerstown merchants.

5:00 pm - 6:00 pm

PERSONNEL HIRING, RETENTION AND FIRING

Janet Cline Patrick
President, Medical Personnel
Services, Inc.



Ms. Patrick will discuss personnel management issues which concern all involved in human resources.

6:30 pm - 7:30 pm

You are welcome to attend a reception with music by the Percussion Ensemble of the Maryland Symphony Orchestra and hosted by the Washington County Medical Society.

**GIANT
SALES & BARGAINS
JUMPER**

Gorham
Hathaway/Olga/Warner's
Izod
J. Crew Factory Store
John Henry & Friends for Men
Johnston & Murphy
Jones New York
The Leather Loft
LEggs/Hanes/Bali
Leslie Fay
Levi
London Fog
Paper Factory

Perfumania
Pfaltzgraff
Polo/Ralph Lauren
Ribbon Outlet
Robert Scott & David Brooks
Royce Hosiery
Silver Sky Jewelry
Socks Galore
Stephen Street Emporium

Totes/Sunglass World
Toy Liquidators
Trader Kids
Van Heusen
Wallet Works by Amity
West Virginia Fine Glass
Woolrich Outlet

Lunch on your own at one of three eateries—
The American Deli, Judy's Restaurant or Clock
Cafe.

Scientific Sessions

Thursday, May 12, 1994

8:30 am - 5:00 pm

REGISTRATION/EXHIBITS OPEN

9:00 am - 4:00 pm

AUXILIARY 45TH ANNUAL MEETING

9:00 am - 11:00 am

STEP-BY-STEP: DOCUMENTING YOUR CME PROGRAM

Committee on Continuing Medical Education Review

Speakers:

William L. Thomas, M.D.

Chair, Committee on Continuing Medical Education Review

Joan Mannion, M.S., M.Ed.

Director, Department of Continuing Medical Education, Med Chi

Susan Dilles, B.S.

Education Unit, Upjohn Company

Objectives: Participating physicians will understand

- ⌘ what documentation is necessary to demonstrate compliance with the seven "Essentials" and
- ⌘ how to document compliance with the "Standards for Commercial Support of the CME"

Target Audience: All physicians involved in planning CME activities and supporting organizational staff

CME Credits: 2.0

Essentials
of Accreditation

9:00 am - 11:00 am

TRIALS AND DELIBERATIONS IN MEDICINE

Committee on Scientific Activity and Medical Mutual Liability Insurance Society of Maryland (Med Mutual)

(Medical Mutual members who attend this session are eligible for a 5% premium discount on their 1995 medical professional liability renewal policy. A \$40 program fee is required for this discount.)

Speakers:

Daniel E. Kohn, M.D.

Associate Director, Harbor Hospital Center

Beth A. Petree, J.D.

Claims Moderator, Medical Mutual

Marilys Gilbert

Claims Supervisor, Medical Mutual

Objectives: Participating physicians will

- ⌘ be able to identify current patient care issues,
- ⌘ have an increased knowledge of medical diagnostic and treatment options,
- ⌘ be able to describe the legal process, from service of suit through trial, and
- ⌘ be able to discuss the application of risk management recommendations.

Target audience: All physicians

CME Credits: 2.0



11:00 am - 11:30 am

BREAK - VISIT THE EXHIBITS

11:30 am - 1:00 pm

AIDS AWARENESS AND DETECTION: ADOLESCENTS, WOMEN AND YOUNG ADULTS

Committee on AIDS, Women in Medicine Committee and Immunizations and Infectious Diseases Subcommittee of the Committee on Public Health

Speakers:

Robert J. Ancona, M.D.

Chair, Immunizations and Infectious Diseases Subcommittee of the Committee on Public Health; Chief, Department of Pediatrics, Union Memorial Hospital

Stanley I. Blum, M.D.

Chief, Division of Otolaryngology, North Arundel Hospital

Jean Anderson, M.D.

Assistant Professor, Department of Obstetrics and Gynecology, Johns Hopkins University School of Medicine

Margaret T. Snow, M.D.

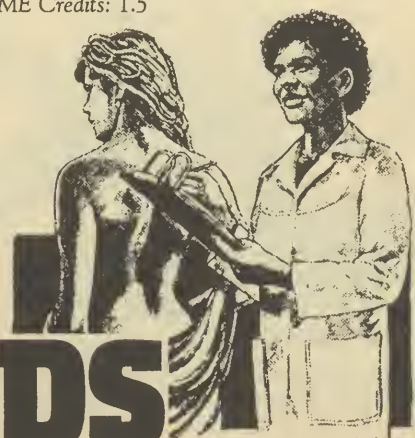
Chair, Committee on AIDS

Objectives: Participating physicians will be

- ⌘ better able to recognize the manifestations of undiagnosed HIV, particularly in women and young people
- ⌘ more knowledgeable about the importance of specialist involvement in the treatment of HIV positive patients and patients with AIDS,
- ⌘ aware of the most recent advances in evaluation and treatment of HIV-positive patients and patients with AIDS.

Target Audience: All physicians

CME Credits: 1.5



AIDS

Medicine Under Health System Reform—Impact on Patients and Physicians

Jesse C. Coggins Memorial Lecture

11:30 am - 1:00 pm

HEALTH CARE DECISIONS ACT: NEW RIGHTS AND RESPONSIBILITIES

Long-Term Care and
Geriatrics
Committee



Speaker:

Jack Schwartz, Esq.

Office of the Attorney General

Overview of the Health Care Decisions
Act as it Pertains to Physicians' Rights and
Responsibilities in Patient Care

Panel:

Jack Schwartz, Esq.

Timothy Keay, M.D., M.A.

Chair, Patient Care Advisory Panel, Deaton
Specialty Hospital, University of Maryland
School of Medicine

Henry Silverman, M.D.

Chair, Committee on Professional Ethics,
Director MICU, University of Maryland
Medical System, Inc.

Objectives: Participating physicians will

- be aware of the rights and responsibilities of physicians in patient care under the Health Care Decisions Act and
- be aware of criteria and procedures for implementing decision-making in various settings, such as intensive care units, nursing homes and offices.

Target Audience: Family practitioners,
psychiatrists and internists

CME Credits: 1.5

1:00 pm - 2:00 pm

LUNCH ON YOUR OWN

1:00 pm - 2:00 pm

WOMEN IN MEDICINE LUNCHEON

Registration and a \$10 fee are required to
attend this luncheon. See page 3 for details.

2:00 pm - 5:00 pm

(Break 3:30 pm - 4:00 pm)

MEDICINE IN TRANSITION: STRATEGIES FOR CHANGE

(Panel Presentation)

Committee on Managed Care and Third-Party
Liaison

Moderator:

Benjamin Avrunin, M.D.

Chair, Committee on Managed Care and
Third-Party Liaison

Objectives: Participating physicians will

- review the definitions and economics of managed care,
- take a close look at President Clinton's health system reform plan, federal legislation and the implications for physicians,
- acquire a deeper understanding of the managed care marketplace with an emphasis on local and regional trends and issues,
- confront, in a rational and realistic way, the dilemmas physicians may face — issues of autonomy, control, competition, loss of revenue, ethical concerns, administrative hassles, and legal issues, and
- gain insight into how physicians can - and should - control clinical decision making in managed care.

Target Audience: All physicians

CME Credits: 2.5

3:30 pm - 4:00 pm

BREAK - VISIT THE EXHIBITS

5:00 pm - 6:00 pm

OFFICE AND CLINIC SECURITY RISKS

Medical Mutual Liability Insurance Society of
Maryland

Speaker:

John Piper

President, Scientech, Inc.

Objectives: Participating physicians will

- be aware of security risks in offices, clinics, hospitals and nursing homes and
- know steps that can be taken to minimize these risks.

Target Audience: All physicians and office
personnel

CME Credit: None



5:00 pm - 6:00 pm

THE IMPACT OF NEW TECHNOLOGY AND COST CONTROL AND TREATMENT OPTIONS FOR BPH (BENIGN PROSTATIC HYPERPLASIA)

Committee on Scientific Activity and the
Division of Neurology, University of
Maryland

Speaker:

Michael J. Nasland, M.D., M.B.A.

Assistant Professor of Urology, The
University of Maryland School of Medicine;
Director, Maryland Prostate Center

Objectives: Participating physicians will be

- aware of new medical treatment options for benign prostatic hyperplasia (BPH)
- aware of developing technologies that will probably play a role in BPH treatment, such as laser, microwave and stents and
- able to discuss an economic model that can be used to quantitatively compare the long-term cost of treating BPH with surgery vs. medications.

Target Audience: Family practitioners,
internists, surgeons and other physicians
who treat elderly men

CME Credit: 1.0

5:00 pm - 6:00 pm

WHAT PHYSICIANS NEED TO KNOW ABOUT TUBERCULOSIS TODAY

*Immunizations and Infectious Diseases
Subcommittee of the Committee on Public Health*

Speakers:

William Randall, M.D.

Maryland State Pulmonologist

Diane Matuszak, M.D.

Chair, Maryland Committee for the Elimination of Tuberculosis

Objectives: Participating physicians will be able to

- ☞ describe the changing epidemiology of tuberculosis in the US and Maryland,
- ☞ describe new treatment guidelines for tuberculosis including recommendations for an initial four-day drug regimen and directly observed therapy (DOT) and
- ☞ describe OSHA requirements for control of tuberculosis

Target Audience: Primary care physicians

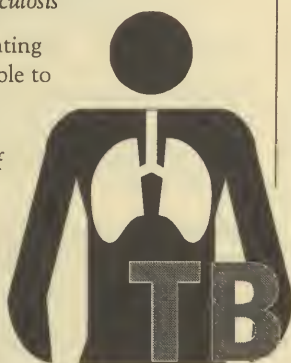
CME Credit: 1.0

6:30 pm - 7:30 pm

WELCOME RECEPTION SPONSORED BY THE RAMADA INN IN THE BALLROOM

Exhibits open

See "Special Events" on page 3 for details.



Scientific Sessions

Friday, May 13, 1994

7:30 am - 5:00 pm

REGISTRATION/EXHIBITS OPEN

8:00 am - 9:30 am

PRAYER BREAKFAST

Registration and a \$6.00 fee are required to attend this breakfast. See page 3 for details.

THE CURRENT IMPERATIVE FOR AN ETHICAL RENAISSANCE IN MEDICINE

Committee on Medicine and Religion

Speaker:

M. Roy Schwarz, M.D.

Senior Vice President for Medical Education and Science, American Medical Association

Objectives: Participating physicians will be more aware of

- ☞ the problems of ethical misconduct within the medical profession, and the impact these are having on the physician/patient relationship,
- ☞ the question of the credibility of physicians and physician leadership on biomedical ethical issues and
- ☞ possible solutions to these problems.

Target Audience: All physicians

CME Credit: 1.0

8:00 am - 10:00 am

PATIENT EDUCATION AND THE MEDIA: WHEN "60 MINUTES" COMES KNOCKING

*Committee on Scientific Activity and
Committee on Young Physicians*

Speaker:

Patricia Clark

Director, AMA Media/Speech Training Services

Objective: Participating physicians will

- ☞ gain skills enabling them to communicate more effectively and authoritatively with patients, with the public in small and large groups, and on radio and television.

Target audience: All physicians

CME Credits: 2.0

8:30 am - 5:00 pm

AUXILIARY - 45TH ANNUAL MEETING

9:30 am - 11:30 am

COUNCIL MEETING

WELCOMING REMARKS:

The Honorable Roscoe Bartlett

US House of Representatives, Maryland 6th District

11:30 am - 1:00 pm

LUNCH ON YOUR OWN

1:00 pm - 2:00 pm

HEALTH SYSTEM REFORM IN MARYLAND

Speakers:

William Richardson, Ph.D.

*President, The Johns Hopkins University;
Chair, Health Care Access and Cost Commission*

Alex Azar, M.D.

Commissioner, Health Care Access and Cost Commission

Objective:

- ☞ Participating physicians will be aware of the issues and problems regarding health system reform at the state level.

CME Credit: 1.0

2:00 pm - 2:30 pm

BREAK - VISIT THE EXHIBITS



**60
MINUTES**

2:30 pm - 5:00 pm

**HOUSE OF DELEGATES
MEETING**

**KEYNOTE
ADDRESS:**

Robert E.
McAfee, M.D.

President-elect, American Medical Association

5:00 pm - 6:00 pm

**GENERAL MEMBERSHIP
MEETING**



KEYNOTE SPEAKER

Robert E. McAfee, M.D.

*President-elect, American
Medical Association*

Dr. McAfee, a surgeon
practicing in South Portland,
Maine, served as vice-

chairperson of the American Medical Association (AMA) Board of Trustees from June 1990 to 1992. He served as a member of the Executive Committee of the board from 1988 to 1992. He was appointed to serve as an AMA commissioner to the Joint Commission on Accreditation of Healthcare Organizations in January 1986 and continues in that capacity. He also served as president of the AMA Education and Research Foundation from 1986 to 1988, and as its secretary-treasurer from 1985 to 1986.

Born in Portland, Maine, Dr. McAfee received his M.D. degree from Tufts University School of Medicine in 1960. He completed his residency in general surgery at Maine Medical Center in 1965. He is a diplomate of the American Board of General Surgery, an attending surgeon at the Maine Medical Center and chief of vascular surgery at Mercy Hospital in Portland. He is also an associate professor at the University of Vermont.

6:30 pm - 7:30 pm

**RECEPTION WITH THE
PERCUSSION ENSEMBLE OF
THE MARYLAND SYMPHONY
ORCHESTRA**

*Hosted by the Washington County Medical
Society.*

See "Special Events" on page 3 for details.

Scientific Sessions



Saturday, May 14, 1994

7:30 am - 12:00 noon

**REGISTRATION/EXHIBITS
OPEN**

8:00 am - 9:00 am

**MEDICINE UNDER
HEALTH SYSTEM
REFORM: IMPACT ON
ACADEMIC MEDICAL
CENTERS**

*Committee on Scientific Activity and
the University of Maryland Medical
System*

Speakers:

Stephen C. Schimpff, M.D.

*Executive Vice President, University
of Maryland Medical System;
Professor of Medicine, Pharmacology,
and Oncology, University of
Maryland School of Medicine*

Frank M. Calia, M.D.

*Vice Dean, Professor of Medicine,
University of Maryland School of
Medicine*

Objectives: Participating physicians
will be able to discuss

❧ indicators of managed care
market evolution and Maryland's
position in this continuum,

❧ purchaser
needs and
expectations in a
managed care
environment,
❧ threats and
opportunities
facing academic
medical centers
in managed care

environments and

❧ key elements for an effective integrated
health services delivery system.

Target Audience: All physicians

CME Credit: 1.0

8:00 am - 9:00 am

**EVALUATION AND TREATMENT
OF DIZZINESS**

*Committee on Scientific Activity and the Dept.
of Otolaryngology-Head and Neck Surgery,
University of Maryland Medical System*

Speaker:

Douglas E. Mattox, M.D.

*Professor and Director, Otolaryngology-Head
and Neck Surgery, University of Maryland
Medical System*

Objectives: Participating physicians will

❧ understand the pathophysical mechanisms
underlying the symptom of vertigo,
❧ be able to differentiate between central
and peripheral vertigo,
❧ be able to diagnose syndromes of
peripheral vertigo and
❧ be able to medically manage syndromes
of peripheral vertigo.

Target Audience: Family practitioners

CME Credit: 1.0

8:00 am - 9:00 am

**CURRENT TRENDS IN THE
MANAGEMENT OF HEAD AND
NECK CANCER AT
WASHINGTON COUNTY
HOSPITAL**

Committee on Scientific Activity

Speaker:

Aryeh L. Herrera, M.D.

*Diplomate, American Board of Plastic
and Reconstructive Surgery*

Objectives: Participating physicians
will

❧ be aware of the incidence rates of
head and neck cancer treated at
Washington County Hospital and
❧ be able to discuss surgical, medical
oncologic and radiotherapeutic methods
currently used in the management of
head and neck cancer in a county
hospital setting.

Target Audience: Family practitioners,
internists and surgeons

CME Credit: 1.0



Medicine Under Health System Reform — Impact on Patients and Physicians



8:00 am - 9:30 am

SUCCESSFUL INVESTMENT STRATEGIES FOR PHYSICIANS

Physician's Practice Digest

Pre-registration is required for this breakfast meeting. See page 3 for details.

Speaker:

Marianne Billek-Kuta

Investment Executive, Ferris, Baker, Watts, Inc.

Objective: Participating physicians will be

- ☞ updated on current trends in investment strategies, including the risks and benefits associated with investments in stocks, mutual funds, real estate and art.

Target Audience:

All physicians

CME Credit: None



9:00 am - 3:00 pm

BUS TRIPS - HISTORICAL DAY OR OUTLET SHOPPING

Registration and an additional fee are required for these trips. See page 4 for details.

9:00 am - 10:00 am

ADVANCES IN TECHNOLOGY AND DRUGS

Speaker:

Robert A. Ingram

President and Chief Operating Officer, Glaxo, Inc.

Objective: Participating physicians will

- ☞ become familiar with the impact of health system reform on research and development in the pharmaceutical industry

Target Audience: All physicians

CME Credit: None



9:00 am - 11:00 am

FAMILIES UNDER SIEGE — PHYSICIANS' ROLE IN COMBATING FAMILY VIOLENCE

Committee on Public Health and Public Relations Committee

Speakers:

Robert McAfee, M.D.

President-elect, American Medical Association

Martin P. Wasserman, M.D.

Chair, Committee on Public Health

Hiroshi Nakazawa, M.D.

Chair, Public Relations Committee

Joanne Tulonen

Executive Director, Maryland Alliance Against Family Violence

Objectives: Participating physicians will

- ☞ learn about the AMA's initiative against family violence,
- ☞ learn about the Maryland Physicians' Campaign Against Family Violence
- ☞ identify physician barriers to dealing with family violence,
- ☞ identify appropriate physician responses to family violence,
- ☞ identify victim barriers to seeking assistance,
- ☞ identify victim responses to family violence and
- ☞ learn about community response to family violence

Target Audience: All physicians

CME Credits: 2.0

9:00 am - 10:00 am

BREAKFAST MEETING—MARYLAND ASTHMA AND ALLERGY SOCIETY MEMBERS

10:00 am - 12:30 pm

(Break 11:00 am - 11:30 am)

BETA AGONIST AND INHALED CORTICOSTEROIDS: CURRENT ISSUES AND CONTROVERSIES

Maryland Asthma and Allergy Society

Speakers:

John H. Toogood, M.D., F.R.C.P.C.

Director, Allergy Clinic and Laboratory, Victoria Hospital, London, Ontario, Canada; Research Professor of Medicine, University of Western Ontario

Harold Stanley Nelson, M.D.

Co-Director, Allergy-Immunology Training Program, University of Colorado School of Medicine, Denver, Colorado; Professor of Medicine, University of Colorado School of Medicine

Objectives: Participating physicians will

- ☞ be able to describe the most current accepted practices in the use of beta agonist therapy and inhaled corticosteroids in the treatment of asthma,
- ☞ be aware of the controversies surrounding the therapies and
- ☞ be knowledgeable about treatments being developed.

Target Audience: Family practitioners, internists, allergists, pulmonologists, pediatricians and endocrinologists

CME Credits: 2.0

10:00 am - 11:00 pm

CONSUMER RESPONSE TO HEALTH SYSTEM REFORM OPINION POLLS

Committee on Scientific Activity

Speaker:

Edward Goetas, III

President and CEO, Tarrance Group

Objectives: Participating physicians will

- ☞ understand how the public is responding to health system reform plans and
- ☞ discuss the most current findings of health system reform public opinion polls.

Target Audience: All physicians

CME Credit: 1.0

Medicine Under Health System Reform—
Impact on Patients and Physicians

Registration Form

PLEASE PRINT CLEARLY:

Name _____

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Spouse name (if attending the annual meeting) _____

CHECK ALL THAT APPLY

SCIENTIFIC SESSION REGISTRATION

| | Cost | # of Tickets | Total |
|---|-----------|--------------|-------|
| <input type="checkbox"/> Med Chi member | no charge | _____ | _____ |
| <input type="checkbox"/> Preregistered non member | \$100.00* | _____ | _____ |

*includes all CME presentations unless an additional charge is noted below

EVENT PRE-REGISTRATION

(See pages 3-4 for details on these events.)

| | | | |
|---|-----------|-------|-------|
| <input type="checkbox"/> Women in Medicine Luncheon | \$10.00 | _____ | _____ |
| Thursday, May 12, 1994, 1:00 pm - 2:00 pm (Open to all women physicians and their spouses) | | | |
| <input type="checkbox"/> Prayer Breakfast (CME Credit: 1.0) | \$6.00 | _____ | _____ |
| Friday, May 13, 1994, 8:00 am - 9:30 am | | | |
| <input type="checkbox"/> Investment Strategies for Physicians | no charge | _____ | _____ |
| Sponsored by Physician's Practice Digest Saturday, May 14, 1994, 8:00 am - 9:30 am | | | |

Bus Trips

Saturday, May 14, 1994, 9:00 am - 3:00 pm
A minimum of 20 participants is needed for these events; if a trip is canceled due to insufficient registration, registrants money will be refunded.

| | | | |
|---|---------|-------|-------|
| <input type="checkbox"/> Choice A - Historical Day | \$25.00 | _____ | _____ |
| <input type="checkbox"/> Choice B - Martinsburg Outlets | \$9.00 | _____ | _____ |
| <input type="checkbox"/> Presidential Banquet | \$50.00 | _____ | _____ |
| Saturday, May 14, 1994, 6:30 pm - 11:00 pm | | | |

Grand Total _____

Return this form with your check made payable to "Med Chi" to:

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Medicine Under Health
System Reform—Impact on
Patients and Physicians

Saturday,
May 14, 1994

11:00 am - 11:30 am

BREAK - VISIT THE EXHIBITS

11:30 am - 12:30 pm

**THE INSURANCE COMMISSION
AND YOU**

Speaker:

Dwight K. Bartlett, III

*Insurance Commissioner for the State of
Maryland*

12:30 pm - 2:00 pm

LUNCH ON YOUR OWN

12:30 pm - 2:00 pm

**MARYLAND MEDICAL
POLITICAL ACTION
COMMITTEE (MMPAC)
LUNCHEON MEETING**

Speaker:

William Alexander, M.D.

American Medical Political Action Committee

Registration required. See page 3 for details.

2:00 pm - 4:00 pm

**HOUSE OF DELEGATES
MEETING**

(Council Meeting immediately follows
House of Delegates meeting.)

6:30 pm - 11:00 pm

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page 3 for
details.





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Speak Out

Words from the Mesozoic Era of Medicine

The eulogy for Dr. Pickett¹ and its editorial rebuttal² (October 1993) contain sound points. A middle ground, however, would offer a more appropriate stance.

Perhaps I may qualify as a dinosaur member of the Mesozoic Era of medicine as I graduated in 1935, a time before the antibacterial substances were isolated and before many of the numerous highly technological instruments were created. Undoubtedly, the practice of medicine has become easier and more rewarding to the patient and the doctor as areas of disease once considered inviolate to discovery and therapy can now be found and attacked successfully.

The bashing of the newer, more costly methods is not intended, but in some, if not many, instances, a less expensive diagnosis method could be used. During the early part of the 1970s, only two sites existed in Baltimore where computed tomography (CT) could be done. Now, any number of centers for the performance of magnetic resonant imaging (MRI) may be found. One wonders, sometimes, if plain roentgenograms could provide, in many instances, the required diagnostic information at less expense.

The matter of concern is not the use, therefore, but the abuse of these wonderful technologic advances in diagnosis and treatment. They are glorious but seriously overused.

Consider briefly the problem of laparoscopic cholecystectomy. In a recent survey of a private, independent health maintenance organization (HMO), the incidence of the operative procedure increased by 59% in one year and the total annual expenditure rose by 11.4%, although the patients routinely had a shorter hospital stay. Surely, the removal of a gallbladder with silent stones will add little to lower the incidence of gallbladder cancer and produce slight change in life expectancy.

Since the advent of antibacterial substances, every innovation has been attended by a rise in the expenditure of federal funds for health care. The projected sum for 1993 is \$211 billion. Because cost is the linchpin of any project to solve our present health care dilemma, some cutbacks will be necessary. Reducing the number of patients undergoing hemodialysis,

Speak Out

coronary bypass, and laparoscopic cholecystectomy and increasing the use of simpler, less expensive, diagnostic instruments should attract serious attention.

Occasionally, the present era may be bewildering for the oldsters in the profession as they learn of the newer things. One great factor operating in their favor, however, is their ability to plug into the patient, listen, assemble the information, and think before acting. Would that all of the practitioners of today had the rapport with patients that Dr. Pickett evidently possessed. Today, many patients who visit physicians need only reassurance about their maladies and the use of a medication for relief. The real instances of difficulty may then be given proper investigation and specific therapy by referring the patient to a specialist.

References

1. Buckley JW. Dinosaurs. *Md Med J* 1993; 42:976-77.
2. Knodell RG. Jurassic Park revisited. *Md Med J* 1993; 42:970-71.

JOSEPH M. MILLER, M.D.
Timonium, Maryland ■

Speak Out is a *Maryland Medical Journal* department created to enable *Med Chi* members to voice their opinions, convictions, or feelings about medicine and related subjects in a more lengthy format than is normally afforded by a letter to the editor. Please send *Speak Out* submissions, as well as letters to the editor and manuscripts, to the Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585.

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Carpal tunnel syndrome surgery may harm patients' hands

Over the past decade or more, there has been an epidemic of carpal tunnel syndrome. The precise etiology of these cases is not completely understood. Some cases are believed to be work related and associated with repetitive use of the hands and wrists.

Within the past several years, the endoscopic carpal tunnel release procedure has been introduced. The instrumentation for this has been heavily publicized and marketed by the manufacturers of the various instruments. There has been little attention focused on the complications of this form of surgery. I want to bring to readers' attention that this treatment method for carpal tunnel syndrome is fraught with risks and, if damage is done to the critical structure of the hand, the consequences are irreversible and occasionally devastating.

The surgery's purpose is to release the transverse carpal ligament to decompress the median nerve. This ligament maintains the elliptical shape of the carpal canal. When the ligament is divided, several things always happen. First, the architectural strength of the elliptical configuration of the carpal canal is lost. Second, the critical pulley system that guides the flexor tendons from the forearm into the hand is destroyed and allows bow stringing of the flexor tendons when the wrist is in a flexed posture. Third, the origins of the thenar muscles and the hypothenar muscles are weakened because of their attachment to this ligament. Fourth, the roof over the contents of the carpal canal is opened, and the natural protection from the underlying structures is lost.

The endoscopic release is performed by a specially designed instrumentation using an endoscope with a television monitor to guide the knife that transects the transverse carpal ligament. In my practice, my colleagues and I are beginning to see disastrous results from this procedure. These complications have been laceration of the ulnar artery in the loge of Guyon, injury to the sensory and motor components of the ulnar nerve, laceration of flexor tendons, complete or partial laceration of the median nerve, laceration of the superficial arch of the ulnar artery in the palm, and incomplete ligament release. (Major complications of open carpal tunnel surgery are similar to those described for the endoscopic release, but a tender palmar scar may also result. However, the incidence of nerve and artery injury is almost nil.) A thousand successful cases can be done by this technique, but one complication, such as noted above, will negate all the successes.

For those surgeons who are skilled and well qualified to do endoscopic procedures, they will and should continue to offer it. For those who are less skilled, it may be a very dangerous operation for the patient. Patients must be informed carefully and must understand the open versus the endoscopic release of the carpal tunnel. (When comparing successful outcomes of the two techniques and barring any complications, it has been my observation that six months postoperation, there is no difference in patient satisfaction.)

It is my suspicion that we will continue to see complications from endoscopic carpal tunnel release into the foreseeable future. This procedure

is industry driven, without accurate assessment of its complications. It can be very costly in terms of dollar values and lingering morbidity.

I hope I have made my point clear.

GAYLORD L. CLARK, JR., M.D.
Dr. Clark is a hand surgeon in Baltimore, Maryland ■

Trivial Pursuit: what did the 1902 medical school application ask?

Medical schools and their application forms have changed radically over the last century. An opportunity to see an application for admittance to the Johns Hopkins University School of Medicine for 1902 provided a humorous comparison with the 1994 version and evoked a bit of nostalgia.

The early application form was quite simple, requesting only the following information:

- The applicant's full name and date of application.
- The applicant's year and place of birth, as well as his or her address.
- The name of the applicant's parent or guardian.
- One letter of introduction and the name of correspondent.
- The names of chief institutions where the applicant had obtained his or her previous education.
- The works the applicant has read in Latin.
- Whether the applicant can read ordinary French and German prose.
- Whether the applicant has had the required training in physics, chemistry, and biology. (Certifying certificates were needed from the pertinent institutions.)

A second page was devoted to purely personal items.

- The applicant's place of residence including exposure [where were the windows], the number of rooms with approximate cubical size, heating appliances, and sanitary conveniences.
- The type of food the applicant consumed including information on the applicant's boarding house and the rate paid, whether the applicant drank milk, and whether unboiled city water was used.
- The amount of sleep the applicant got, whether the window was wide open at night, and the number of occupants in the room.
- Whether the applicant had a regular time for exercise and what was the nature of the exercise.
- Under habits, the applicant was asked:
 - Do you take a cold bath each morning?
 - Is there any tuberculosis in your family or in the home where you live?
 - Do you consume food, tea, coffee, or alcoholics in excess?

As the medical school curriculum has become more complex, the applica-

tion has become much more detailed. The present version asks for a detailed history including undergraduate and graduate schools attended, and the occupation(s) of the applicant's family members. Scores from one of the standardized pre-application examinations and college grades in required courses are also requested. Two pages are devoted to the applicant's personal life.

The older application I had the opportunity to see was dated September 16, 1902, and was for admission to the class of that year. The applicant was accepted and graduated in 1906. How different is the course of events now? Applications must now be submitted a year in advance and only a chosen few are selected for interviews and even fewer for eventual admission.

I wonder how many men and women of my age could have passed muster facing this modern questionnaire. I am certain that 60 years ago, we were not instructed as well as students of today. Apparently, a sufficient number of "good" men and women were available, however, to be taught and build for the future.

JOSEPH MILLER, M.D.
Timonium, Maryland ■

Tobacco kills

It is now 30 years since the publication of the US surgeon general's landmark report identifying tobacco as the chief cause of lung cancer. Tobacco remains the number one drug problem and the leading public health problem in the United States as well as all other industrialized countries. More than 450,000 deaths per year are **directly** related to tobacco use—a figure that exceeds the mortality due to alcohol, cocaine, AIDS (acquired immunodeficiency syndrome), and the Vietnam conflict combined.

Yes, we have made progress in the war against tobacco—the percent of smokers has declined from a high of 40% in the early 1960s to some 25% currently. Unfortunately, the decline has been arrested, and, in 1993, there were disturbing indications of an increase, particularly among teenagers and women.

On February 1, 1994, the American Cancer Society statistics for 1993 were released. Once again, Maryland was near the top of the list (a hair's breath below Delaware). If we are to see a real decline in these figures, we must, as physicians, recognize our responsibility in getting the message to our pa-

tients that **tobacco kills**. We must let our elected officials know that we want stringent restrictions on where vending machines can be located to help curb the illegal sale of cigarettes to minors. We must let the members of the Administrative, Executive, and Legislative Review Committee (AELR) know that we want the MOSH (Maryland occupational safety and health) regulation banning smoking in the workplace to go into effect intact.

We must let our representatives in Congress know that we want Representative Waxman's (D-29th, CA) excellent clean air bill, HR 3434, voted on in committee and brought up in both chambers of Congress this year. Finally, we must keep out of our homes and offices all magazines, such as *Sports Illustrated*, that carry tobacco advertising.

In this anniversary year, let us show the tobacco industry that we **can** overcome. Surely we owe our children no less.

MIRIAM KLEBANER, M.D., F.A.A.P.
Dr. Klebaner is the tobacco, alcohol, and drug issues coordinator, Maryland Chapter, American Academy of Pediatrics ■

AELR Committee members

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Co-chairperson Sen. Paula C. Hollinger (Dist. 11, Baltimore County), 841-3131
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In praise of mini-internships

On behalf of all the physicians of the Montgomery County Medical Society, I would like to add my praise of the mini-internship program, which was discussed in the November 1993 issue of the *Maryland Medical Journal* [Auxiliary: "Mini-internship pilot program in Anne Arundel County," page 1155].

The Montgomery County Medical Society held its first two internship programs in the spring and fall of 1993. In all, 13 interns—including legislators, reporters, attorneys, and business

leaders—shadowed our physician members throughout a two-day period. Both internship programs proved to be tremendous success stories—for physicians and interns alike. The insights the interns gained as a result of their experiences were invaluable; all left the debriefing dinner with a new perspective on the physician-patient relationship, government regulations, third-party intrusions into the practice of medicine, and health system reform.

Perhaps there is no better way to describe the success of the program

than by sharing a comment made by one of our interns, a state legislator, after his experience: "We in the legislative arena have to try to safeguard the medical profession as much as we can, to make sure that the needs of the patient come first."

The mini-internship program proves that we **can** make a difference, even if it means educating one person at a time.

DONALD S. STEPITA, M.D.

Dr. Stepita is president, Montgomery County Medical Society. ■

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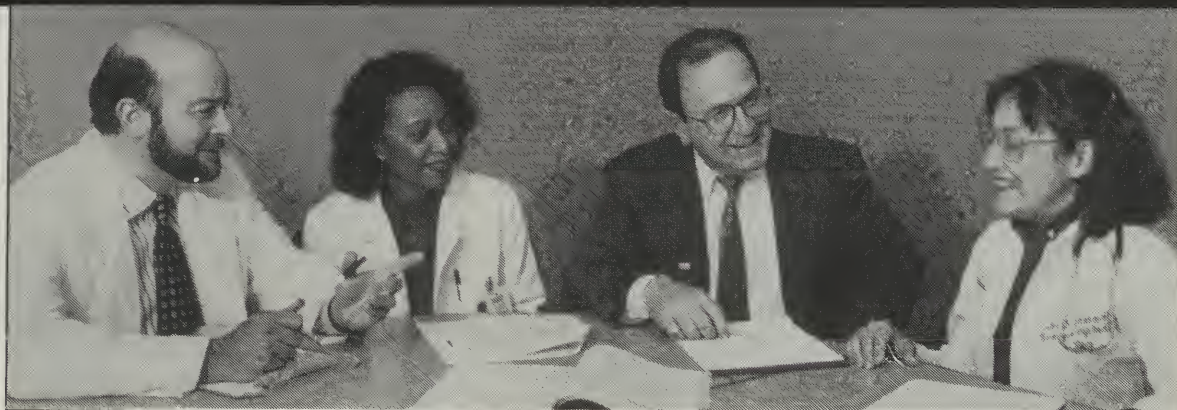


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Mr. Donald Kirson
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Kirson Medical

Dr. Kathryn Yamamota
Family Medicine
Emergency Medicine

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Dr. D'Orta... "How is that possible that it's so less expensive than staying in a hospital?"

Donald Kirson... "Well, home medical companies provide service, but don't have the overhead that a hospital or a long term care facility would have."

Dr. Barnett Scott... "What are the advantages to home care?"

Donald Kirson... "People want to be at home. They want to be home with the family. They are able to lead a pretty normal life."

Dr. Barnett Scott... "What happens if there is an emergency?"

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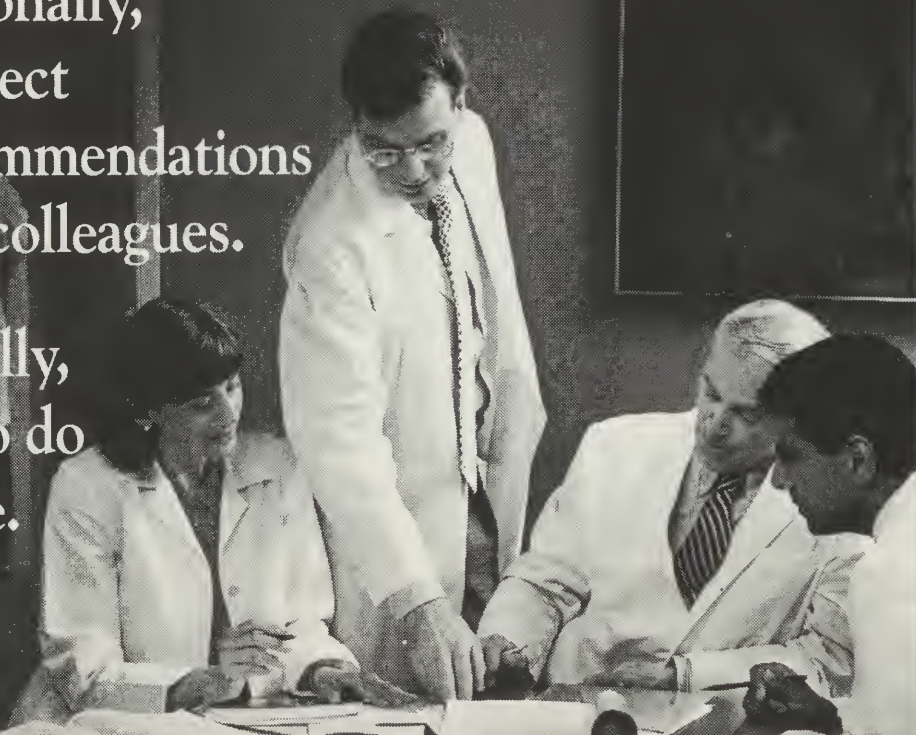
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I N T E L L I G E N T , I N D I V I D U A L I Z E D F I N A N C I N G

Church Home and Hospital: where caring is part of the cure

Janet Emerick

Ms. Emerick is director of community and media relations, [Church Home and Hospital, Baltimore, Maryland.]

ABSTRACT: *For 137 years, Church Home and Hospital has been providing high quality health care to the poor, the elderly, and the sick living in the eastern Baltimore metropolitan area. The institution is unusual in many ways, not the least of which is the loyalty of its staff. Prime examples of this loyalty are T.G. Whedbee, Jr., the hospital's president and chief executive officer, who is retiring this year after nearly three decades with Church Home and Hospital, and Jose M. Yosunico, M.D., former chief of staff and past Med Chi president, who has been associated with the institution he loves for 40 years.*

This dynamic and innovative institution, which made a commitment to serve its urban neighbors when other medical facilities fled to the suburbs, was the first in the state to establish a hospice, an intensive care unit, a residence for patients with Alzheimer's disease, a satellite urgent-care center, and a patient care program based on severity of illness. These are only a few of the many creative programs that the hospital has implemented over the years to enhance patient care—programs that have served as models for hospitals across the nation.

Following World War II and during the early 1970s, when many Baltimore hospitals packed up and moved to the surrounding suburbs, Church Home and Hospital resolved to remain on its original site—the top of Washington Hill overlooking historic Fells Point. Since opening its doors to the sick and homeless in 1857, Church Home and Hospital—a merger of Church Home Society and St. Andrews Infirmary—has had an impact far beyond its own walls, the surrounding community, and the state.

Table 1. Church Home and Hospital highlights

- ✦ Church Home and Hospital was the first in the state and one of the first in the nation to establish a hospice service.
- ✦ The institution established the first intensive care unit in Maryland.
- ✦ The Broadway Wing was the first residence established for patients with Alzheimer's disease.
- ✦ The Health Center at Dundalk was the first satellite urgent-care center in Maryland.
- ✦ Church Home and Hospital was the first to create a medical mall, with offices for more than 50 physicians to serve the community.
- ✦ The hospital was the first on the east coast to implement a program of progressive patient care based on severity of illness.
- ✦ The Church Home and Hospital corporate structure, consisting of separate subsidiaries within a parent corporation, has been used as a model by hospitals across the nation since 1974.
- ✦ The institution was among the first to offer hospital-based home care and adult day care in Baltimore.
- ✦ It is the only Baltimore metropolitan organization to offer high-tech acute, subacute, and skilled nursing care services, as well as retirement living, on one campus.
- ✦ Church Home and Hospital opened the first bloodless medicine and surgery center in the mid-Atlantic region.

Innovations at Church Hospital (**Table 1**), including a specialized life-residence for patients with Alzheimer's disease, hospital-based hospice care for terminally ill individuals, and the now common practice of freestanding urgent-care centers and medical malls, are clearly the legacy of one man who has been chief executive officer (CEO) of Church Home and Hospital for nearly three decades—T.G. Whedbee, Jr.

Mr. Whedbee became CEO at the age of 33. While serving at Church Hospital, he has seen dramatic changes in the health care system, including the inception of Medicare and Medicaid, and the proliferation of regulatory agencies such as the Health Services Cost Review Commission (HSCRC) and the Central Maryland Health Systems Agency (HSA) that have had such a significant influence on all hospitals.

While such leadership consistency may seem unusual in any industry, prolonged association with this institution is a tradition—the rule rather than the exception. There have been many physicians and administrators whose working lives have been linked closely with Church Home and Hospital over the past 137 years. The hospital's greatest debt may go to the revered “three musketeers” of the early 1900s—Drs. Tom Cullen, Guy Hunner, and Griff Davis. They came early in their careers to help establish the hospital of their dreams—an institution founded to care for the sick

and the homeless and to serve as a haven for the elderly in their twilight years.

Today, the tradition of long-term association with the hospital continues with the appointment of James R. Bobb as president designate. Mr. Bobb, currently serving as executive vice president of Church Hospital, has been Mr. Whedbee's



Figure 1. Over 113 years of medical staff and administrative leadership are represented by President T.G. Whedbee, Jr.; Mesbah U. Dowla, M.D., chief of staff; James R. Bobb, president designate; Jose Yosucio, M.D., past Med Chi president, and past Church Hospital chief of staff; and George M.S. Riepe, president of the Board of Trustees of Church Home and Hospital.

career-long colleague, coming to work at the institution in 1966. Together with George M. S. Riepe, president of the Board of Trustees for more than a quarter century, these three individuals have become the longest enduring health care executive team in the state (**Figure 1**). Early on, this team established a bond with its leading physicians. One such individual is former chief of staff, Jose M. Yosunico, M.D., who celebrates his 40-year association with Church Hospital this year (**Figure 2**).

Dr. Yosunico exemplifies the Church Hospital physician—a man who still makes house calls, many to people who have been patients of his for more than 30 years. Originally from the Philippines where he grew up wanting to be a priest, Dr. Yosunico is a founding member of several Filipino societies and has been honored by the ambassador of the Republic of the Philippines for his “exceptional contributions to the medical profession.” He is also the recipient of the 1987 Alumnus of the Year award and the 1994 Outstanding Alumnus award from the University of the Philippines Medical Alumni Society in America. In addition, Dr. Yosunico is one of only 146 physicians who has served as Med Chi president during the past two centuries.

Jack M. Zimmerman, M.D., another of the longtime leading physicians at Church Home and Hospital, has been chief of surgery since 1965 and has been at the forefront of many innovations, including the hospice movement and bloodless surgery. He also found time to author the foremost medical text book on hospice care, *Hospice: Complete Care for the Terminally Ill*.

The current chief of staff, Mesbah U. Dowla, M.D. (**Figure 3**), has a history with Church Hospital beginning some 25 years ago. After an internship and residency at Church Hospital, Dr. Dowla left for the Medical College of Virginia, where he completed a gastroenterology residency. He returned to Church Hospital—just as so many other physicians have done who value Church Hospital’s commitment to patient care—and was appointed chief of gastroenterology.

The family tree

Since the days of its founding as Church Home and Infirmary (the name change to “Church Home and Hospital” occurred in 1943), when it was just a single brick building with a rounded cupola with a domed roof surmounted by a gilt wooden cross (**Figure 4**), the hospital has treated and cared for Europeans by the thousands, Lumbee Indians from North Carolina, and African-Americans from worn-out southern farms, who came to Baltimore in search of a new life. While providing care for the sailors and the iron workers, the tailors and the boilermakers, the old and the feeble, the



Figure 2. Jose M. Yosunico, M.D., a 40-year associate of Church Home and Hospital, stands in front of the stained glass window in the Church Hospital boardroom with a man whom he is proud to call friend, T.G. Whedbee, Jr. (the dean of CEOs).



Figure 3. James R. Bobb, president designate, and Mesbah U. Dowla, M.D., chief of staff, look to the future, hoping to carry on Church Hospital’s proud traditions.



Figure 4. Church Home and Hospital's landmark cupola dates back to 1836 when the building was the site of Washington Medical College. The cross dates back to the War of 1812.

prosperous and the not so prosperous of Fells Point, Washington Hill, Highlandtown, Canton, Dundalk, and eastern Baltimore County, Church Hospital witnessed the growth, decline, and revitalization of one of the most dynamic communities on the eastern seaboard.

Following World War II, the once lively and prosperous neighborhood surrounding Church Hospital slipped toward decay, like so many other neighborhoods in the inner city. Church Hospital, however, obliged by its presence and conscience, continued to care for the increasing number of poor who depended on it.

In the early 1970s, the area surrounding Church Hospital took a turn for the better when many resolute community residents, with support from a farsighted city administration and some federal dollars, renovated rowhouses and formed community and business partnerships that encouraged a repopulation of the neighborhood. Church Hospital continues to assist in the ongoing revitalization by supporting community beautification activities and working closely with neighborhood organizations.

The end of an era

T. G. Whedbee, Jr., who is retiring in May 1994 after almost three decades as hospital president and chief executive officer at Church Home and Hospital, was born in Edenton, North Carolina, on May 4, 1932. A graduate of Wake Forest University and the Medical College of Virginia, Mr. Whedbee is married to the former Marianne Farnell and has three children and one grandchild.

Mr. Whedbee began his career at Church Hospital in 1960 as an assistant director, after completing an administrative residency program at Roanoke Memorial Hospital. He is known as the "dean of CEOs" because he has served longer than any other incumbent hospital CEO in Maryland.

Throughout his career, Mr. Whedbee has been committed to his employees and has been an advocate of promotion from within the institution, which has had a significant impact on employee loyalty to, and pride in, the hospital. Early in his career, Mr. Whedbee developed a corporate structure unique to the hospital industry—separate subsidiaries within a parent corporation; this structure has served as a model for hospitals across the nation. Due to his leadership, the medical mall and freestanding urgent-care concepts were brought to the east coast.

In addition to his dedication to Church Home and Hospital, Mr. Whedbee has long been involved with the community, serving as a member and often, as president, of many boards, including the Baltimore Rotary Club and the Maryland Hospital Association. He also served for many years as delegate to the American Hospital Association.

A modest individual, Mr. Whedbee has devoted his career to serving Church Home and Hospital and the surrounding communities. As James Bobb, president designate, says, "Gil Whedbee shines his light on a lot of new ideas, but he never shines his light on himself."

The services and facilities

Church Hospital is an acute care, not-for-profit, 216-bed hospital. Although it has strong historic ties to the Episcopal Church, it is nondenominational. The hospital provides medical, surgical, gynecological, hospice, subacute, home care, and adult day care services, and also operates a 24-hour emergency room. The newly opened subacute service, known as Recover Care, expands the hospital's "seamless care" concept with a 31-bed transitional care unit. No other metropolitan medical institution offers high-tech acute, subacute, and skilled nursing care services, as well as retirement living, on one campus—a campus that has grown from one landmark structure to a multi-building complex.

Church Hospital shares its campus with Church Home, a 92-bed retirement home for the elderly; an adjacent 22-room residence—known as the Broadway Wing—for people suffering from Alzheimer's disease; and a 55-bed comprehensive nursing home (Fairmount Nursing Center) that will soon be expanded to a 150-bed facility on the west side of the existing complex. Future projects include a new physician office building across from the hospital's main entrance.

In 1979, Church Home and Hospital opened the Health Center at Dundalk, a walk-in treatment center with professional office suites. It was the state's first medical mall, offering convenient, one-stop, urgent-care and outpatient diagnostic services to the people and businesses of the Dundalk community. It was a model that has since been copied repeatedly throughout the country. Its occupational health component, CompCare Plus, now serves more than 100 area businesses and industries. Other Church Hospital satellite health centers offering primary and specialty physician services have since opened in White Marsh in Baltimore County and in the east Baltimore neighborhood of Canton.

For 137 years, Church Home and Hospital has ministered to the poor and sick in the eastern Baltimore metropolitan area, adapting and changing its services as needed. With Mr. Whedbee's retirement, one chapter of Church Home and Hospital's history comes to a close. However, with the continued dedication and support of its physicians, other health professionals, and administrative staff, this dynamic and innovative institution will continue to thrive. ■

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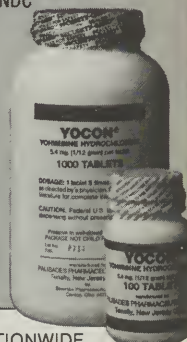
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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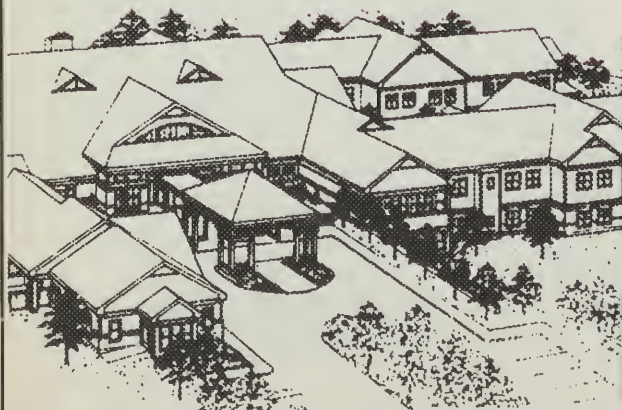
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Breast cancer prevention trial

E. George Elias, M.D., Ph.D.; Sally D. Brown, R.N., B.S.N., O.C.N.;
Barbara S. Buda, R.N., B.S.N., M.G.A., O.C.N.; and Sharon L. Honts, A.A.

From the Department of Surgery, University of Maryland School of Medicine, where Dr. Elias is professor of surgery and oncology; Ms. Brown and Ms. Buda are oncology research nurses; and Ms. Honts is program development officer.

ABSTRACT: *The incidence of breast cancer continues to rise and now affects one in eight women, despite major early-detection efforts. The Breast Cancer Prevention Trial (BCPT), under the auspices of the National Surgical Adjuvant Breast and Bowel Project (NSABBP), will evaluate the effect of tamoxifen in reducing the incidence of invasive breast cancer, breast cancer mortality, cardiovascular mortality, and bone fractures. A total of 16,000 healthy women 35 years of age or older will be randomized to receive tamoxifen or a placebo over a five-year period. As of March 1993, 42% of the needed study participants had been enrolled in the trial. The University of Maryland is participating in the BCPT, and Maryland physicians can refer potential study participants to 12 locations throughout Maryland.*

Breast cancer is a major health problem that has a significant impact on our society. In the United States, an estimated 183,000 new cases will be diagnosed, and 46,000 patients will die of this disease during 1993. Breast cancer constitutes 19% of all cancer deaths in women. Furthermore, over 1.5 million women will be diagnosed with this disease by the year 2000. In Maryland, 3,400 new cases of breast cancer will be diagnosed in 1993, and 850 patients will die of this disease.¹

Currently, the three ways to attack breast cancer are: (1) therapy for those with diagnosed breast cancer, including surgery, radiation therapy, and systemic therapy in the form of chemotherapy or hormonal therapy, or a combination of these; (2) screening for early diagnosis, which gives the patient various therapy options and a better prognosis; and (3) prevention. **Figure 1** schematically shows the effect and value of each approach.

Disease prevention is a long-standing and well-established practice. Numerous public health measures to prevent disease and improve health are part of everyday life: fluoridating water supplies to help prevent tooth decay;

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Presented at the 195th Annual Meeting of Med Chi on May 1, 1993, at the University of Maryland College Park.

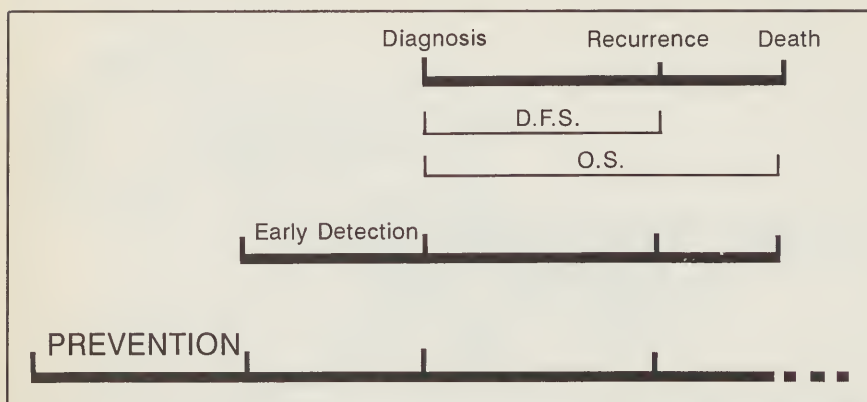


Figure 1. Theoretical schema to express the beneficial effect of each attack methods on cancer in general. Once the diagnosis is clinically established, the disease-free survival (DFS) and the overall survival (OS) are established. These may have been improved by adjuvant therapy. Early detection may increase survival by establishing the diagnosis at an early stage. Prevention of cancer can give true long-term survival.

chlorinating water to prevent bacterial growth; and vaccinating people to prevent disease. Through diet and lifestyle changes, such as reducing fat and salt consumption, stopping smoking, reducing alcohol intake, and exercising, people make conscious choices to try to prevent disease and stay healthy. As research and technology improve, they reveal new ways to prevent disease; for example, research has shown the beneficial effect of aspirin in preventing heart disease.

Breast cancer prevention, the result of extensive research, has been a topic of discussion and heated debate for the last decade. Breast cancer, which is now on the rise in women, affects one in eight women. The estimated 183,000 new cases of breast cancer for 1993 will not develop overnight. If a breast cancer cell doubles in 100 days, it will take approximately eight years to develop a palpable mass in the breast. It is conceivable, then, that one million women have nondetectable biological or pathological breast cancers today. Detecting breast cancer early is accomplished by physical examination to rule out the presence of breast masses (and enlarged regional lymph nodes) and by mammography. Most information on breast cancer is based on palpable breast masses, and mammograms have lowered the threshold of detection. Currently, however, a large number of women have phenotypic cancers that are below the threshold of detection. Therefore, to improve breast cancer prevention, we need to seek women with normal breasts but identifiable risk factors.

The National Surgical Adjuvant Breast and Bowel Project (NSABBP), established in 1958 under the chairpersonship of Dr. Bernard Fisher, has over 250 centers in the United States and Canada with more than 6,000 physicians, nurses, and other medical professionals. The University of Maryland is an active member of this international force. NSABBP's primary mission is to alter the surgical and adjuvant therapy of breast

cancer. More than 30,000 patients have received cancer treatment in NSABBP clinical trials.

Based on NSABBP's experience in accruing and collecting reliable and valid data, the National Cancer Institute chose NSABBP to extend its activities into breast cancer prevention. The Breast Cancer Prevention Trial (BCPT), which is being conducted at 118 selected centers in the United States and Canada, was initiated in April 1992. It is supported by the National Cancer Institute, the National Heart, Lung and Blood Institute, and the National Institute of Arthritis and Musculo-Skeletal and Skin Diseases, and is endorsed by the American Cancer Society.

The BCPT, which is the first prevention trial of its kind in the United States and Canada, will involve 16,000 healthy women who are at increased risk for developing breast cancer. Eligible women who enroll in the BCPT will be randomly assigned to receive tamoxifen (Nolvadex) or a placebo in the form of two tablets per day for five years.

Objectives of the trial

The BCPT's objectives are to evaluate the effect of tamoxifen in reducing the incidence of invasive breast cancer; breast cancer mortality; cardiovascular mortality; and bone fractures.

Justification for using tamoxifen

Any breast cancer prevention strategy must meet certain prerequisites, including strong supportive evidence from basic research in the laboratory and clinical evidence showing safety and effectiveness. Tamoxifen (Nolvadex), which was synthesized in 1966, is rapidly absorbed in the gastrointestinal tract, metabolized by the liver, and slowly excreted, mainly in the bile, as conjugates. The drug reaches a steady state in four weeks when taken as 10 mg tablets twice daily. Its half life is seven days.

The first clinical trial with tamoxifen was reported in 1971. Since then, many studies have proved its effectiveness and safety in advanced disease and in the adjuvant setting (i.e., postmastectomy) in patients with metastasis to their axillary lymph nodes and, later, in those without lymph node metastases. In five major trials, it was noted that tamoxifen therapy reduced the incidence of another carcinoma in the opposite breast by 50%. The studies demonstrating the worth of tamoxifen were the NSABBP Protocol B-14; the Stockholm Trial; the Scottish Trial; the Cancer Research Campaign Adjuvant Breast Trial; and the Nolvadex Adjuvant Therapy Organization Trial.²

Tamoxifen has often been labeled as an antiestrogen. However, it does not block production of estrogen, but rather

competes with estrogen at the tumor cell receptor sites. Recent studies have shown that tamoxifen seems to stabilize bone loss much like estrogen. Therefore, it may decrease fracture rates in older women.

More interesting was the concern that tamoxifen might have an effect on cardiovascular disease. It is well recognized that after menopause, some women experience a rise in serum cholesterol and a subsequent increase in cardiovascular disease. However, several studies have shown that tamoxifen actually reduces total cholesterol primarily by reducing low density lipoproteins.³ The Scottish Trial has already reported a significant reduction in cardiovascular deaths in women receiving tamoxifen.⁴

Tamoxifen, like any other drug, has some side effects. Women receiving tamoxifen may experience hot flashes, vaginal dryness, and discharge. On rare occasions, they may complain of nausea. Other side effects include leukopenia and thrombocytopenia on very rare occasions.

Endometrial carcinoma has been reported in 0.29% of patients receiving tamoxifen compared with 0.12% of controls. Deep vein thrombosis may occur, as in other hormonal therapy, such as with the use of estrogen with or without progesterone. The reported incidence is about 0.4% compared with the control rate of 0.1%. This can be prevented largely by low doses of aspirin. Retinal abnormalities, which are reversible if tamoxifen is discontinued, have been reported in four of the thousands of individuals who have received tamoxifen.⁵ Hepatomas have been reported in rats receiving 20 to 100 times the dose used in humans, but have not been seen in patients receiving 20 mg tamoxifen per day. Overall, these side effects are reported very rarely, and the benefit exceeds the risk.

Mechanism of action of tamoxifen

Tamoxifen acts primarily by competing with estradiol molecules for estrogen receptor sites in the cytoplasm of tumor cells. It decreases both tumor growth factor alpha and the levels of insulin-like growth factors that stimulate tumor cell growth. In the meantime, it increases tumor growth factor beta, which suppresses tumor cell growth. In addition, tamoxifen increases sex-hormone-binding globulin, which may decrease the availability of free estrogen, and it increases the level of natural killer cells.

Who is at risk for developing breast cancer?

The BCPT's determination of who is at risk of breast cancer is based on the Surveillance Epidemiology and End Results

Table 1. Eligibility criteria for participation in the Breast Cancer Prevention Trial

| Age | Eligible risk profile |
|----------|---|
| 35 | One or more first-degree relatives with breast cancer and a personal history of at least two benign breast biopsies OR diagnosis of lobular carcinoma <i>in situ</i> (LCIS) |
| 40 | Two or more first-degree relatives with breast cancer OR a personal history of two benign breast biopsies OR diagnosis of LCIS |
| 45 or 50 | One or more first-degree relatives with breast cancer OR a personal history of two benign breast biopsies OR diagnosis of LCIS |
| 55 | One or more first-degree relatives with breast cancer OR first live birth after 30 years of age OR diagnosis of LCIS |
| 60+ | Eligible regardless of specific breast cancer risk factors |

(SEER) data and on a model developed by M.H. Gail. SEER data have indicated that one of the strongest risk factors for breast cancer is age. At age 35, women's risk of developing breast cancer is 66 per 100,000 population. This risk increases to 334 per 100,000 by age 60. The Gail model, however, provides a composite estimate of risk based on a combination of factors derived from Breast Cancer Detection Demonstration Project data, which were obtained from 280,000 healthy women. The Gail model estimate of risk takes into account genetic (family history) and nongenetic factors such as the number of first-degree relatives (mother, sisters, daughters) with breast cancer, the number of benign breast biopsies, previous breast biopsies showing atypical hyperplasia, age at menarche and at spontaneous menopause, and nulliparity or age of the woman when she delivered her first live birth. It also includes women who have a history of lobular carcinoma *in situ* treated by lumpectomy.

BCPT eligibility and follow-up

To be eligible to participate in the BCPT, a woman must be 35 years of age or older and must satisfy the criteria listed in **Table 1**. Interested women must complete a risk assessment form to determine initial eligibility. Prior to entering the study, potentially eligible women must have a normal CBC (complete blood count) and blood chemistries, a breast examination with normal results, and a recent mammogram that shows no suspicious lesions. Interested women also must have a pelvic examination and a Pap smear. Women who are 55 years old or older must have a baseline ECG (electrocardiogram). After an initial interview, completion of informed consent procedures, and an eligibility review, candidates are randomized to receive tamoxifen or a placebo in the form of two tablets daily for five years.

All subjects will be followed in the same fashion. Follow-up will include breast examination, CBC, and blood chemistries

twice yearly, and a mammogram and a pelvic examination with a Pap smear once per year. Women over 55 years of age will have an ECG every three years.

Some women may refuse to participate in the trial because they may receive the placebo. However, in this trial, all participants will be under careful surveillance. The increased monitoring will serve as early detection.

Status of the trial

The Breast Cancer Prevention Trial began accepting eligible candidates in April 1992. As of March 1993, 6,719 women had been randomized into the study. These women constitute 42% of the BCPT's goal of 16,000 enrollees. The researchers hope that all physicians in Maryland and surrounding areas will support this very important trial by referring potentially eligible women.

The University of Maryland is a nucleus subcenter for the BCPT, having established several satellites throughout the state. Contact personnel are listed in Table 2.

References

1. Boring CC, Squires TS, Tong T. Cancer statistics, 1993. *CA Cancer J Clin* 1993; 40:18-23.
2. Fisher B, Redmond C. A new perspective on cancer of the contralateral breast: a marker for assessing tamoxifen as a prevention agent. *J Natl Cancer Inst* 1991;83:1278-80.
3. Love RR, Newcomb PA, Weibe DA, et al. Effects of tamoxifen therapy on lipids and lipoprotein levels in postmenopausal patients with node-negative breast cancer. *J Natl Cancer Inst* 1990; 82:1327-32.
4. McDonald CC, Stewart HJ. Fatal myocardial infarction in the Scottish adjuvant tamoxifen trial. The Scottish Breast Cancer Committee. *BMJ* 1991; 303:435-37.
5. Paulidis NA, Petris, C Briassoulis E, et al. Clear evidence that long-term low-dose tamoxifen treatment can induce ocular toxicity. *Cancer* 1992; 69:2961-64. ■

Table 2. Maryland contact persons for the Breast Cancer Prevention Trial

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Fifteen things you should know about new Maryland laws when making health care decisions

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ABSTRACT: *Recent dramatic changes to Maryland law regarding health care decision making for incapacitated patients will have significant impact on the role of physicians in making these decisions. On October 1, 1993, the newly passed Maryland Health Care Decision Act took effect, and revisions to state guardianship laws were implemented.*

The laws, which Governor Schaefer approved on May 11, 1993, modify existing statutory language pertaining to the four legal tools available for making health care decisions for a person when he or she becomes incapacitated: (1) living wills, (2) substituted consents for medical procedures, (3) health care power of attorney appointments, and (4) guardianship proceedings.

This article summarizes 15 important points in these new or revised Maryland laws on health care decision making.

At three o'clock in the morning, you are working in the acute side of a hospital emergency room. Paramedics arrive with an automobile accident patient with severe crush injuries to the head, face, and chest. Despite massive anesthesia, pulmonary, and cardiology treatment given in the emergency room, later electroencephalogram studies show virtually no brain wave activity.

Soon, relatives arrive at the hospital. They learn, painfully, of the patient's poor prognosis for return of cognitive functioning. You hear relative Colleen mention that the patient has a living will somewhere. Another relative, John, tells you he has a power of attorney from the patient, and as a result, he is the patient's agent and will soon issue instructions to withdraw ventilation, nutrition, and hydration from the patient.

Sometime later, still another relative, Polly, approaches and tells you that, contrary to what Colleen says, no living will exists for the patient who, according to Polly, only mentioned to a few people once at a party that it might

be a good idea to execute a living will. Polly also tells you that John, while very close to the patient, is somewhat mistaken about the extent of his authority as power of attorney. John, you learn, has financial powers for the patient, but not health care powers.

Polly believes the patient should be kept alive by any means possible, no matter how bad the prognosis for future function of the brain. John disagrees. Colleen, still in shock from the sad news, does not know what to think. Other relatives continue to arrive. Everyone looks to you, the treating physician, and asks you to tell them what happens next.

What do you do?

Recent changes to Maryland law offer hope that your job will become easier with cases involving health care decision making for incapacitated patients. On October 1, 1993, when the newly passed Maryland Health Care Decision Act took effect and when revisions to state guardianship laws were implemented, Maryland's health care decision-making laws underwent dramatic changes.

The laws, which Governor Schaefer approved on May 11, 1993, modify existing statutory language pertaining to the four legal tools available for making health care decisions for a person when he or she becomes incapacitated: (1) living wills, (2) substituted consents for medical procedures, (3) health care power of attorney appointments, and (4) guardianship proceedings.

By tracking these additions and revisions, this article provides readers with a summary of 15 important points about these new or revised Maryland laws regarding health care decisions for incapacitated patients.

Fifteen important aspects of the additions and revisions to these laws, which will be codified as Title 5 of the Maryland Health-General Article and Title 13 of the Maryland Estates and Trusts Article, include the following items.

1. How to use advance directives and living wills. A competent individual may make a written or oral advance directive to appoint a health care agent or to instruct the providing, withholding, or withdrawing of health care, including life-sustaining procedures. A competent individual may also make an advance directive by executing a written living will, which allows the declarant to make decisions about life-sustaining procedures if, in the future, he or she becomes terminally ill or is in a persistent vegetative state.

A written directive must be witnessed by two persons, neither of whom can be a health care agent for the declarant, and at least one of whom cannot be entitled to any financial benefit from the estate of the declarant. An oral directive must be made in the presence of the declarant's attending physician and one other witness and must be documented by the physician and the other witness.

In both written directive and oral directive situations, the directive itself must be placed in the declarant's medical record. Physicians may not presume that the absence of an advance directive indicates the patient's intent to consent to or refuse life-sustaining procedures. A declarant who appoints a health care agent may grant the agent authority to carry out the declarant's wishes at the very moment he or she signs the advance directive document, as opposed to granting authority later when the declarant becomes incapacitated.

Suggested forms are provided in the statute for execution of living wills, appointments of health care agents, and execution of advance medical directive health care instructions. The suggested forms in the statute are intended only as guides. Portions of the suggested forms or different forms may be used. An owner, operator, or employee of a health care facility who is treating the declarant may not serve as a health care agent unless that person qualifies as a surrogate decision maker (described in item 2 of this article).

An advance directive may be revoked at any time by a declarant by a written cancellation, by a physical cancellation or destruction, by an oral statement to a health care practitioner, or by execution of a subsequent advance directive.

2. Surrogate decision makers who substitute consent. The new law permits specified individuals to exercise surrogate decision-making powers and substitute consent for patients who are incapacitated and who have not already appointed a health care agent or executed another suitable advance directive. In such instances, a guardian of the person, a spouse, an adult child, a parent, an adult sibling, or a close friend, pursuant to this described priority list, may be permitted to make decisions affecting the provision, withholding, or withdrawal of life-sustaining treatment for the patient. When a dispute exists among surrogates who possess equal statutory priority, the patient's physician shall refer the case to the health care institution's Patient Care Advisory Committee and may act in accordance with the recommendations of that committee.

The physician may also transfer the patient if certain transfer provisions (described in item 10 of this article) are followed. A physician in such surrogate situations is immune from liability for any claim based on lack of consent or authorization for the action.

When the patient is not in a hospital or related institution, the physician may not withhold or withdraw life-sustaining treatment if surrogates in the same class of priority do not agree. In order to exercise such surrogate power, the surrogate decision maker must base decisions on the wishes of the patient, if known. If those wishes are not known, the decision must be based on the patient's best interest (described in item 15 of this article). In all instances, surrogate decision makers may not authorize sterilization or treatment for a mental disorder.

3. Certification of incapacity by physicians. In order to provide, withhold, or withdraw treatment, the patient's attending physician and a second physician must certify that the patient is incapable of making an informed decision regarding the treatment. They must base their certification on a personal examination of the patient. One of the physicians must examine the patient within two hours of making the certification. When the patient is unconscious or unable to communicate, the certification of a second physician is not necessary.

A health care provider may not withhold or withdraw life-sustaining treatment on the basis of an advance directive in cases where the patient has not appointed an agent or when the authorization is given by a surrogate, unless the two physicians certify that the patient is in a terminal condition or has an end-stage condition, or if two physicians, one of whom is a specialist in neurology or cognitive functioning, certify that the patient is in a persistent vegetative state.

4. Emergency treatment without consent. Health care providers may treat, without their consent, patients incapable of making informed decisions if (1) emergency treatment is needed; (2) no authorized person is available to consent; (3) the attending physician sees a substantial risk of death or serious harm; and (4) the physician believes, to a reasonable degree of medical certainty, that the life or health of the patient would be adversely affected by delaying such treatment.

5. Emergency medical personnel facing "do not resuscitate" orders in the field. The new law provides authorization to emergency medical personnel in the field to follow "do not resuscitate" (DNR) orders if the order in question conforms to protocols established by, and available from, the Maryland Institute for Emergency Medical Services Systems (MIEMSS). The law also permits such personnel, in limited instances, to follow certain oral instructions concerning DNR orders.

6. Immunity for health care providers, health agents and surrogates. Health care providers are given immunity from criminal prosecution or civil liability, as well as immunity from a claim for unprofessional conduct, as a result of withholding or withdrawing treatment under authorization contained in the new laws. The same immunity exists for health care providers facing claims based on lack of consent or authorization. Similar immunity from criminal prosecution and civil liability is given to health agents or surrogate decision makers. Health care providers, health agents, and surrogate decision makers are immune from such claims unless it is shown that they lacked good faith and failed to comply with the statutory health care decision provisions.

7. Penalties for destroying or concealing advance directives. New provisions in the law impose criminal penalties on individuals who willfully destroy or conceal an advance direc-

tive in an attempt to counter the wishes of the declarant. These new provisions also permit civil liability exposure as well.

8. Avoiding confusion between medically ineffective treatment and mercy killing. An important new provision states that a physician is not required to prescribe or render to a patient medical treatment the physician determines is ethically inappropriate or medically ineffective. In such instances, a physician must make every reasonable effort to transfer the patient to another health care provider.

Although the provision permits the physician to avoid ethically inappropriate or medically ineffective treatment, it explicitly does not condone, authorize, or approve mercy killing or euthanasia. In all instances, a health care provider shall make reasonable efforts to provide an individual with food and water and to assist with nutrition and hydration needs. A health care agent or surrogate decision maker still may, nonetheless, proceed with a separate decision concerning the withholding or withdrawal of nutrients and fluids by artificial means. However, the health care provider must continue to assist with such needs until instructed otherwise.

9. When health care providers disagree with health agent or surrogate decisions. If a health care provider disagrees with an agent or surrogate decision maker who instructs withholding or withdrawing life-sustaining procedures when, in the provider's view, the decision is inconsistent with generally accepted standards of patient care, then the provider shall petition the Patient Care Advisory Committee for advice if the patient is in a hospital or related institution. When a patient is not in a hospital or related institution, the provider shall petition a court of competent jurisdiction for injunctive relief concerning the health care decision in disagreement. Such cases are given precedence on the court docket and are expedited in every way.

10. Health care provider's obligation to assist with transfer when refusing compliance. A health care provider who intends not to comply with the instruction of a health care agent or surrogate decision maker shall make every reasonable effort to transfer the patient to another health care provider and assist with the transfer and, pending the transfer, comply with the instruction that is the subject of disagreement if a failure to comply with the instruction would likely result in the death of the patient.

11. Preventing uncertainty about suicide and life insurance policies. Under the new laws, the withholding and withdrawing of life-sustaining procedures shall not for any reason be considered a suicide. Such a withholding or withdrawal shall not affect the sale of any life insurance policy or modify the terms of an existing life insurance policy. A life insurance policy shall not be impaired when validated by any such withholding or withdrawal. Persons may not be required

to execute an advance directive or living will as a prerequisite for gaining health insurance or for receiving health care services.

12. Localizing the federal Patient Self-Determination Act. The legislation also codifies and localizes into Maryland law the key provisions of relevant federal law known as the Patient Self-Determination Act of 1991. This new Maryland provision requires all health care facilities to provide each individual, on admittance to the facility, information concerning the rights of the individual to make decisions concerning health care, including the right to accept or refuse treatment and the right to make an advance directive, including a living will.

13. Grandfather clause for existing directives. The legislation indicates that these new provisions are cumulative with respect to existing Maryland laws pertaining to an individual's right to consent or refuse to consent to medical treatment. The passage of this new Maryland law does not impair any rights or responsibilities that existed prior to passage of the new law. Additionally, the new law includes a grandfather clause to uphold the validity of all living wills and durable powers of attorney for health care provided prior to the October 1, 1993, enactment of the new law.

14. Reciprocity extended to directives and orders from other states. The new law also contains a section providing reciprocity for agent instruction and living will advance directives or emergency medical services DNR orders enacted in other states. Those directives, wills, and orders are deemed valid in Maryland if executed in compliance with the laws of Maryland or if executed in compliance with the laws of the state where purported to be executed.

15. Greater latitude and power given to courts and guardians in guardianship proceedings. In addition to substantially modifying provisions of Title 5 of the Maryland Health-General Article to produce the Health Care Decision Act, the new legislation makes significant changes to portions of Title 13 of the Maryland Estates and Trust Article. This portion of the Estates and Trust Article deals with appointment and powers of legal guardians.

The new changes to Title 13 now permit a court, when it considers it appropriate, to authorize a guardian to make a decision regarding medical procedures that involve a substantial risk to life, without further court authorization, if the disabled person has already executed an advance directive in accordance with the Health Care Decision Act but simply has not appointed a health care agent, or if the guardian is a spouse or close family relative. A court may approve a request for such withholding or withdrawing if it finds, on the basis of substituted judgment, that the disabled person would, if competent,

make the same health care decision regarding the life-sustaining procedure. Such a finding by the court must be made by clear and convincing evidence; also, the rules of evidence are tempered to permit greater latitude in the admissibility of otherwise inadmissible evidence.

Where a substituted judgment cannot be made, the court then may apply the best interest balancing test to determine whether such a request for withholding or withdrawing of life-sustaining treatment is appropriate. The best interest test weighs the benefits to the disabled person resulting from the treatment against the burdens to the disabled person resulting from that treatment, taking into account emotional and cognitive functions, pain, or discomfort, as well as other ethical issues such as dignity, humiliation, dependency, and religious beliefs. Only upon proof, again by clear and convincing evidence, that the burdens outweigh the benefits will the court order the withholding or withdrawing of life-sustaining treatment.

Conclusion

These 15 points highlight the broad changes made by recent legislation in Maryland law concerning the providing, withholding, and withdrawing of medical treatment to patients who are incapacitated. Additional specific provisions of the new law not fully described here must be followed to meet statutory guidelines. In order to better understand certain nuances in the law and to assure full compliance with the various provisions, interested health care practitioners and health care institution administrators are urged to undertake additional study concerning the many changes to Maryland's health care decision laws. ■

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A computerized geriatric assessment designed for use in primary care physicians' offices

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ABSTRACT: *Comprehensive geriatric assessments have generally been recognized as beneficial for frail elderly patients. However, the complexity of these evaluations has usually required that they be performed in a multidisciplinary setting. Staffing requirements, time commitment, new skill requirements, and reimbursement problems serve as impediments for primary care physicians performing these examinations. Computer technology may be the solution to these problems. A software program has been developed which allows primary care physicians to perform a sophisticated functional assessment on an outpatient basis without the use of a multidisciplinary team. Problems are identified by the computer-assisted protocol and patients are referred for appropriate management. Thus, the physician maintains a primary role in case management. The program is cost effective because it does not require additional staff to operate it and it effectively uses CPT and ICD9 coding.*

Physicians practicing primary care medicine are aware that the patient population is aging. How can primary care physicians respond to the demands of aging patients? *The Merck Manual of Geriatrics*¹ suggests that if physicians perform comprehensive geriatric assessments on every patient, predictable patterns of illness will be identified. However, the 1987 NIH Consensus Conference on the subject of geriatric assessments² stated certain principles that, at first glance, create serious problems for primary care physicians interested in performing these functional assessments in their offices. First, the multidisciplinary nature of these assessments was stressed. Few physicians in private practice have a multidisciplinary team at their disposal. Also, the definition of a comprehensive geriatric assessment requires that, in addition to a routine history and physical exam, there must

| SECTION | TITLE |
|---------|--|
| I | BACKGROUND INFORMATION |
| II | SUMMARY OF HISTORY |
| | A. ILLNESSES |
| | B. CURRENT MEDICATIONS |
| | C. NUTRITIONAL STATUS |
| III | FUNCTIONAL ASSESSMENT INVENTORY |
| | A. MEDICAL |
| | 1. VITAL SIGNS |
| | 2. EXPIRATORY PEAK FLOW |
| | 3. OLFATORY TESTING |
| | 4. HEARING HANDICAP QUESTIONNAIRE |
| | B. FUNCTIONAL DISABILITY |
| | 1. GERIATRIC FUNCTIONAL RATING SCALE |
| | 2. FALL RISK INDEX |
| | 3. SCREENING FOR FUNCTIONAL DISABILITY |
| | C. MENTAL HEALTH |
| | 1. DEPRESSION ASSESSMENT (YESAVAGE) |
| | 2. DEPRESSION ASSESSMENT (JENICKE) |
| | 3. COGNITIVE STATUS (FOLSTEIN) |
| | D. SOCIOECONOMIC CONCERNS |
| IV | ACTIVITIES OF DAILY LIVING |
| | A. FUNCTIONAL ASSESSMENT |
| | SCREENING QUESTIONNAIRE |
| | B. PERSONAL CONCERNS |
| | C. HOME SAFETY CHECKLIST |
| V | PHYSICAL EXAMINATION |
| VI | ASSESSMENT SUMMARY AND RECOMMENDATIONS |

Figure 1. Table of Contents of assessment

be a formal assessment of mental health, functional status and socioeconomic status.

The major barriers for performing functional assessments in a primary care physician's office include³ (1) the time required to use and review acquired data; (2) physician reimbursement problems, (3) the training and new skill development required for physicians so that they can use the functional data obtained; (4) patient perceptions about the importance of learning about their functional status; and (5) the need for physicians to establish a network of health care professionals to manage the problems identified by the comprehensive geriatric assessment.

This paper describes a computer software program that was designed to allow primary care physicians to perform these functional assessments in their offices, in a cost-effective manner. The previously described barriers will be addressed, including the concern about physician reimbursement. Physicians can learn new skills through continuing medical education programs. Physicians who treat many geriatric patients already have established networks with health care professionals who help manage these patients. Therefore, this barrier is

more isolated than it is commonplace. Finally, patients' attitudes about the importance of knowing their functional status will be directly influenced by physicians' enthusiasm about the evaluation.

Physicians already receive laboratory and x-ray reports via fax. Many physicians have computerized billing and patient record systems. Why not use computer technology to streamline a clinical task such as comprehensive geriatric assessment?

Materials and methods

The software program referred to throughout this paper was developed and tested in the author's private practice. The evaluation consists of three office visits.

During the first visit, certain tests, such as mental status evaluation, electrocardiogram (ECG) and laboratory tests can be performed and the evaluation scheduled. Additionally, a copy of the Home Safety Checklist, along with hemocult slides, are given to the patient, with instruction to return these items at the time of the evaluation. The second visit lasts about two hours, during which time the computer prompted interview, physical examination, expiratory peak flow measurement, vision, hearing and olfactory testing are done. The third visit consists of the presentation of the results to the patient and/or interested caregiver, along with recommendations concerning management based on the results of the assessment. A ten to twelve page computer generated report is given to the patient at the third visit. **Figure 1** presents the Table of Contents of this report. Laboratory tests routinely performed with this protocol are complete blood count (CBC), urinaly-

sis, blood chemistry panel and thyroid stimulating hormone (TSH). Peak expiratory flow is measured because it has been shown to be a strong independent predictor of total mortality in the elderly.⁴

The computer prompted interview is conducted on an individual basis by a trained member of the office staff, who keys the responses into the computer. This portion of the test takes 1.25 to 1.5 hours, depending on the cognitive status of the patient. Two controls are used to ensure quality responses by the patient. First, if the subject is accompanied to the office by a relative or caregiver, that person attends the interview. Second, cognitive status is assessed early in the interview, and we demand that a corroborating person be in attendance if the patient scores below 26 on the Mini Mental State Exam.

After the interview is finished, a worksheet (**Figure 2**) is generated by the computer. This worksheet is used by the physician, nurse practitioner, or physician's assistant as a guide during the physical examination. After the physical examination, the examiner creates an active and inactive problem list, adding positive findings observed. This new data

| | | | |
|-------------------------------|---------------------------------|----------------------|---|
| PATIENT: | | | |
| 1. Height | 2. Weight | | |
| 3. Eyesight: L-20/ R-20/ | 4. Hearing: (db loss) L- R- | | |
| 5. Back Exam: Flexible (Y/N): | 6. New Medication in Past Week: | | |
| 7. Blood Pressure | | | |
| Lying: | Systolic: | Diastolic: | |
| Standing: | Systolic: | Diastolic: | |
| 8. Pulse: | 9. Respiration: | 10. Expiratory Flow: | |
| AREA: | Neg | Pos | (Explain positive findings. Items may be identified by number.) |
| 1. Skin | _____ | _____ | _____ |
| 2. Head-eyes | _____ | _____ | _____ |
| 3. Ears | _____ | _____ | _____ |
| 4. Nose | _____ | _____ | _____ |
| 5. Mouth | _____ | _____ | _____ |
| 6. Throat | _____ | _____ | _____ |
| 7. Neck | _____ | _____ | _____ |
| 8. Lymph Nodes | _____ | _____ | _____ |
| 9. Chest | _____ | _____ | _____ |
| 10. Breast | _____ | _____ | _____ |
| 11. Heart | _____ | _____ | _____ |
| 12. Lungs | _____ | _____ | _____ |
| 13. Abdomen | _____ | _____ | _____ |
| 14. Genitalia | _____ | _____ | _____ |
| 15. Rectal | _____ | _____ | _____ |
| 16. Extremities | _____ | _____ | _____ |
| 17. Neurological | _____ | _____ | _____ |

| | |
|--|--------------------------------|
| PATIENT | |
| Client takes the following medication: | |
| Client has relayed the following illnesses. These will either be placed on an Active problem list, or an Inactive problem list. Please mark them with either an (A) or an (I). | |
| For your information: | |
| Mini Mental Score: | |
| Education Level: | |
| Mini Mental Score: | Interpretation: |
| 0 - 24 | Probable Dementia |
| 25 - 27 | Possible Cognitive Dysfunction |
| 28 - 30 | Normal Cognition |

Figure 2. Physician's worksheet

is entered into the computer by the staff member who conducted the interview.

The software is IBM compatible and is written in dBaseIV. The program offers pull-down menus and is easy to use in an outpatient setting. Information gathered during the interview is entered into a database via input screens. If an incorrect response is entered, a message appears on the bottom of the screen telling the operator the correct parameters. To continue, the correct answers must be entered. Individual information can be appended to a master database from which statistics may

be compiled and analyzed for research purposes. The report may also be stored on a 3.5" floppy disk in ASCII format. Hence, the patient can keep this report, and, if an emergency arises, a hospital emergency department can access this information with an IBM compatible computer and word processing software.

The software covers a wide range of information, including nutritional status, functional status including fall risk, socioeconomic evaluation and environmental assessment. Table 1 lists the various tests used in this software.

The Nutritional Risk Index⁵ is depicted in Table 2. It evaluates several parameters that affect nutritional status. The Nutritional Risk Index, along with serum albumen measurement and Body Mass Index computation, provide important information regarding nutritional status.

The Hearing Handicap Questionnaire⁶ and the Welch Allyn audioscope are used to evaluate hearing. Table 3 shows the Hearing Handicap Questionnaire. The audioscope is an instrument which has a pure tone audiometer built into the otoscope that allows the tym-

panic membrane to be visualized while a pure tone, with ranges from 20 db to 40 db, is used to evaluate a patient's hearing.

Olfactory testing is performed using the scratch and smell test developed by the University of Pennsylvania.⁷ Multiple abnormalities in the special senses which may pose significant problems for the elderly⁸ have been identified by performing these comprehensive assessments.

Pulmonary function screening is performed using the ASSESS Peak Flow Meter. As mentioned earlier, since most cause deaths occur in people who score less than 250 L/minute

Table 1. List of tests used in this assessment

- ◆ Biomedical Data
- ◆ Medical Diagnoses (past and present)
- ◆ Nutritional Data
- ◆ Nutritional Risk Index (Wolinsky)
- ◆ Body Mass Index, Serum Albumen
- ◆ Laboratory Tests: CBC, Urine, SMA-18, TSH, Hemocult, Pap Smear
- ◆ Pulmonary Function Testing (Peak Expiratory Flow)
- ◆ Olfactory Testing
- ◆ Hearing Evaluation
- ◆ Hearing Handicap Score
- ◆ Audioscope testing
- ◆ Snellan Eye Chart
- ◆ Functional Assessment
- ◆ Geriatric Functional Rating Scale
- ◆ Functional Assessment Screening Questionnaire
- ◆ Tinetti Gait and Balance Testing/Fall Risk Index
- ◆ Psychological Data
- ◆ Mini Mental State (Folstein)
- ◆ Yesavage Geriatric Depression Scale
- ◆ Jenicke Depression Evaluation (SIG E CAPS)
- ◆ Socioeconomic Evaluation including the Home Safety Checklist

or less,⁴ this score was chosen as an indicator for performance of spirometry testing.

Functional status is assessed using a combination of several tests. These include Basic and Instrumental Activities of Daily Living,^{9,10} Seltzer's Functional Assessment Screening Questionnaire,¹¹ the COPE evaluation described by Pearlman,¹² and the Geriatric Functional Rating Scale of Grauer and Birnbom.¹³ These elements, along with Tinetti's Fall Risk Index,¹⁴ give a broad assessment of one's functional capacity.

The Folstein Mini Mental State Exam¹⁵ evaluates cognitive function. Although there are many cognitive function tests available, this test is used most frequently. Depression is evaluated by two tests. The first is the Yesavage Geriatric Depression Scale¹⁶ and the second is Jenicke's "SIG E CAPS"¹⁷ which is more clinically oriented. In this acronym "S" represents sleep disturbance; "I" stands for loss of energy; "G" is for feelings of guilt; "E" represents energy level; "C" indi-

cates problems with concentration; "A" is a change in appetite (either direction); "P" refers to psychomotor changes, which might be hyper- or hypoactive; and "S" stands for suicidal thought or action. The DMS III criteria for the diagnosis of major depression will be suggested if a person has five of these elements present for two or more weeks. The software also includes several questions regarding psychotic symptomology, hence, it serves as a formal mental status evaluation.¹⁷ The CAGE questions, an assessment of possible alcohol abuse,¹⁸ are interspersed during the interview—two in the nutritional section and two in the depression section.

Socioeconomic and environmental parameters are evaluated using parts of the previously mentioned COPE and Functional Assessment Screening Questionnaire, along with a questionnaire developed by the National Safety Council and AARP.¹⁹

The evaluation software also demands that the patient perform certain tasks. This type of functional testing is described in **Table 4**. For example, patients who state that they are able to shampoo their hair, but cannot touch the top of their head with their fingers have overestimated their capability in that area. Finally, Tinetti's gait and balance testing, a part of the Fall Risk Index,¹⁴ may uncover potentially serious problems that might be helped by referral to a physical therapist. **Table 5** depicts the gait and balance testing performed by this software program.

Physician reimbursement

Rubenstein et al²⁰ suggest either billing for each questionnaire used in the assessment, or increasing office fees to cover the additional expense associated with the testing.

Table 2. Nutrition Risk Index

1. Do you have an illness or condition that interferes with your eating?
2. Do you have an illness that has cut down on your appetite?
3. Do you have trouble biting or chewing any kinds of foods?
4. Are there any kinds of foods that you don't eat because they disagree with you?
5. In the past month, did you have discomfort in your abdomen or stomach on any three or more days?
6. In the past month, did you have any trouble swallowing on any three or more days?
7. In the past month, did you vomit on at least three days?
8. Do you have any trouble with your bowels that gives you constipation or diarrhea?
9. Did you gain or lose any weight in the past month? (Note: net gain/loss must have exceeded 10 pounds.)?
10. Did you ever have an operation on your abdomen?
11. Were you ever told by a doctor that you were "anemic"?
12. Do you wear dentures?
13. Do you smoke cigarettes regularly now?
14. In the past month, did you take any medicines prescribed by a doctor?
15. In the past month, did you take any medicines NOT prescribed by a doctor?
16. Are you on any kind of special diet?

Eight or more positive responses indicate poor nutritional risk

The author proposes that the individual components of the geriatric assessment be billed separately. This method of billing requires appropriate correlation with CPT and ICD9 coding. The initial visit qualifies as a comprehensive exam, which may be also given a "modifier," to use coding parlance. The mental status determination has its own CPT code, as does the olfactory test; however, CPT codes and ICD9 codes must be matched carefully. Peak expiratory flow measurement is not reimbursable, but if normal lung function is demonstrated, then spirometry, a test reimbursable through Medicare, could be indicated. The follow-up visit, at which time the test results are discussed and recommendations

regarding management are made, qualifies as an expanded or detailed consultation. Until a CPT code is assigned for comprehensive geriatric assessment, reimbursement will be subject to changes made by the Health Care Financing Administration (HCFA). In the meantime, careful attention to CPT and ICD9 coding will result in reasonable compensation for physicians who follow this software protocol.

Validation of the software program

It is one thing to collect a series of tests, most of which are already validated for use with elderly patients. It is quite another thing to claim that integrating these tests into a computer software program designed to assist in the performance of geriatric assessments will produce reliable information upon which management decisions will be based.

Such a software program must demonstrate that it performs in a manner similar to those tools currently being used in geriatric evaluation units elsewhere. Parameters of interest include (1) improved diagnostic accuracy in terms of new problems uncovered; (2) ability to predict the eventual need for changes in living status; and (3) ability to track changes in functional capacity by serial testing. If this software is able to adequately perform in these areas, it should be a useful tool for implementing outcome studies on the impact of routine geriatric assessments.

Improved diagnostic accuracy. The first 22 patients from the author's private medical practice documented that 19 new problems were uncovered. Some of the

Table 3. Hearing Handicap Questionnaire

1. Does a hearing problem cause you to feel embarrassed when you meet new people?
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?
3. Do you have difficulty hearing when someone speaks in a whisper?
4. Do you feel handicapped by a hearing problem?
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?
6. Does a hearing problem cause you to attend religious services less often than you would like?
7. Does a hearing problem cause you to have arguments with family members?
8. Does a hearing problem cause you difficulty when listening to television or radio?
9. Do you feel that any difficulty with your hearing limits or hampers your social life?
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?

Scoring the questionnaire:

Each "yes" = 4 points

Each "no" = 0 points

Each "sometimes" = 2 points

A score of 0-8 has a low probability of hearing impairment (13 percent)

A score of 10-24 has about a 50% probability of hearing impairment

A score of 26-40 has about an 85% probability of hearing impairment

Subjects should be referred for further testing if they have: a score above 8 and fail an audioscope examination; a score above 24 even if they pass an audioscope exam.

conditions found were life threatening, including one breast cancer case, and another patient with an abdominal aortic aneurysm.²² Another report discussed the high prevalence of sensory deficits in elderly patients seen in primary care medicine.⁸

Predicting eventual need for change in living status. An important element in a comprehensive geriatric assessment is an evaluation of a person's functional capacity in terms of maintaining his or her independent lifestyle. One hundred and twenty-four patients who had this computer assisted geriatric assessment were followed for 18 to 36 months, and changes in their living status was evaluated. Eighty-five percent (11/13) of those subjects who required a change in living status, either institutionalization or moving in with relatives, were successfully identified by the software program.

Table 4. Functional disability testing

A = performed easily

B = performed with some difficulty

C = unable to perform

1. Touch first metacarpal phalangeal joint to top of head.
2. Touch waist in back.
3. Place palm of hand to palmar crease. If abnormal, test grip strength.
4. Place palm of hand on contralateral trochanter.
5. Touch index finger pad to thumb pad.
6. Sitting, touch toe or shoe.
7. Stand unassisted; step over a six inch block.

Table 5. Balance maneuvers (Tinetti)

Maximum score = 15

Less than 10 = high fall risk

| | |
|--|------------------|
| 1. Sitting balance | Score 0 to 1 |
| 2. Rising from chair (does not get up with single motion; pushes up with arms) | Score 0 to 4 |
| 3. Immediate standing balance (first five seconds) (unsteady at first standing) | Score 0, 1, or 2 |
| 4. Prolonged standing (moves feet, etc.) | Score 0, 1, or 2 |
| 5. Withstanding nudge on chest (moves feet, grabs object for support) | Score 0, 1, or 2 |
| 6. Standing balance with eyes closed (tests reliance on visual input for balance) | Score 0 to 1 |
| 7. Turning balance (360 degrees) (stops before starting turn; staggers, sways, grabs objects for support) | Score 0, 1, or 2 |
| 8. Sitting down (plops in chair; does not land in center) | Score 0 to 1 |

Gait maneuvers (Tinetti)

Maximum score = 13

Less than 9 = high fall risk

| | |
|--|------------------|
| 1. Initiation of gait (hesitates, stumbles, grabs) | Score 0, 1, or 2 |
| 2. Step length | Score 0, 1, or 2 |
| 3. Step height (foot clears floor, 2" high; look for scraping, shuffling over 2" high) | Score 0, 1, or 2 |
| 4. Step continuity (after first few steps, doesn't consistently raise one foot as the other foot touches the floor) | Score 0, 1, or 2 |
| 5. Step symmetry (unequal step length; pathological side is usually longer) | Score 0 to 1 |
| 6. Walking stance | Score 0 to 1 |
| 7. Amount of trunk sway | Score 0 to 1 |
| 8. Path deviation (doesn't walk straight line; weaves side-to-side) | Score 0, 1, or 2 |

Mobility score = combination of gait and balance scores

Maximum score = 28

ated with this test. In September 1992, because of perceived deterioration in her general condition, her daughter requested a repeat assessment. During the time between exams, the patient was followed at regular intervals by the author and a cardiologist. No obvious changes in her general health status were noted by either physician. The second formal assessment revealed a significant reduction in her Geriatric Functional Rating Scale from her baseline of 76 to 51 (normal range is 41 to 101) and a decrease in her Mini Mental State Exam from 26 to 19. Based on this information, her daughter could be advised with reasonable confidence that her mother might be in the early stages of a progressive dementia. Appropriate studies such as CT brain scan, laboratory tests, etc., all proved to be negative. As a follow up on this patient, a repeat Mini Mental State Exam in March 1993 showed a further reduction in score to 17. This patient represents how serial geriatric assessments, aided by the computer software can introduce an element of predictability to the appearance of a very common geriatric syndrome, namely, dementia.

Discussion

The pilot program for this software was performed in a suburban family physician's office.²¹ The program is designed to be integrated into the regular office style of operation so as not to create friction among the members of the staff. The person selected to conduct the computer prompted interview should be the employee who is most familiar with CPT and ICD9 coding, and who is most comfortable interviewing elderly people.

The use of this software by primary care physicians benefits patients and their families in many ways. Previously undiagnosed

problems were found in many patients.^{22,23,24} The information obtained through this program allows patients and their families to evaluate their needs more effectively and make better use of home care services.^{25,26} Additionally, this information can help families make informed decisions about community services or alternate living arrangements for elderly patients. Studies also have shown that geriatric assessment programs have improved cognition and functional status,²⁷ reduced medication usage,²⁸

Ability to track changes in functional capacity. Cognitive function is an important part of a person's functional capacity. Anna Doe, a longtime patient of the author, had a comprehensive geriatric assessment in August 1990. At that time, she was living alone in a senior citizen apartment development. All of the parameters of the computerized assessment were normal at that time, except that her Mini Mental State Exam score was 26. This score was attributed to possible educational bias associ-

reduced nursing home days, and reduced use of hospital services.²⁹ Another recent study suggests that mortality is reduced by inpatient community based geriatric assessment.³¹

It should be noted that none of these positive effects of geriatric assessment has been accomplished by enlisting the help of primary care physicians. It is almost axiomatic that performance of these geriatric assessments by a patient's personal physician would be the most certain way to link such assessments with appropriate patient care management decisions. The assessment might serve as a baseline exam for a compensated, functionally independent senior citizen, as was the case with "Anna Doe." Or, it might uncover a remedial problem such as the curable breast cancer the author found in a patient who had previously refused breast examination, but agreed to have the exam as part of her geriatric assessment. This evaluation might also find an early Parkinsonian patient with the gait and balance exam, or other problems that might benefit from physical therapy intervention.

In addition, this software program is suitable as an adjunct to the geriatric training programs for family practice and internal medicine residencies. It also has the potential for research studies designed to evaluate outcome of various interventions in patient care and management that incorporate comprehensive geriatric assessments as part of the intervention process.

Summary

This IBM compatible software program allows primary care physicians to perform a sophisticated comprehensive geriatric assessment in their offices. It affords primary care physician the opportunity to assume responsibility in the case management of their elderly patients instead of allowing other health care providers to assume control of the day-to-day case management. Further studies that compare this software with more traditional, multidisciplinary comprehensive geriatric assessment protocols are indicated.

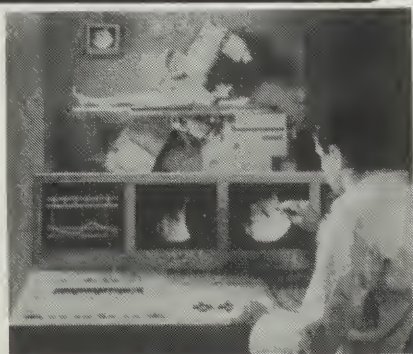
References

1. Fretwell MD, In: Abrams WB, Berkow R. (eds). *The Merck Manual of Geriatrics* 1990; 174.
2. National Institutes of Health Consensus Development Conference Statement: Geriatric assessment methods for clinical decision-making. *J Amer Ger Soc* 1988; 36:342-47.
3. Rubenstein LZ, Calkins DR, et al. Health status assessment for elderly patients. Report of the Society of General Internal Medicine task force on health assessment. *J Amer Ger Soc* 1988; 37:562-69.
4. Cook NR, Evans DA, Schere PA, et al. Peak expiratory flow rate and five year mortality in an elderly population. *Amer J Epidemiol* 1994; 133(8):784-94.
5. Wolinsky P. Nutrition risk index. *Amer J Prev Med* 1985; 1:53-59.
6. Lichtenstein MJ, Bess FH, Logan SA. Validation of screening tools for identifying hearing impaired elderly in primary care. *JAMA* 1988; 259:2875-78.

7. Doty RL, Shaman P, Dann M. Development of the University of Pennsylvania smell identification test: a standardized microencapsulated test of olfactory function. *Physiology and Behavior* 1984; 32:489-502.
8. Devore PA. Prevalence of olfactory dysfunction, hearing deficit and cognitive dysfunction among elderly patients in a suburban family practice. *Southern Med J* 1992; 85:894-96.
9. Katz S, Downs TD, Cash HR. Progress in the development of the index of ADL. *Gerontologist* 1970; 10:20-30.
10. Lawton MP, Brody EM. Assessment of older people: self-monitoring and instrumental activities of daily living. *Gerontologist* 1969; 9:179-86.
11. Seltzer GB, Grainger CV, Wineberg BA. Functional assessment: bridge between family and rehabilitation medicine within ambulatory practice. *Arch Phy Med Rehabil* 1982; 63:454-57.
12. Pearlman RA. Development of a functional assessment questionnaire for geriatric patients: the comprehensive older person's evaluation (COPE). *J Chron Dis* 1987; 40:855-945 (Suppl).
13. Grauer H, Birnbaum F. A geriatric functional scale to determine the need for institutional care. *J Am Ger Soc* 1975; 20:472-76.
14. Tinetti ME, Williams TF, Mayewski R. Fall risk index for elderly patients based on number of chronic disabilities. *Am J Med* 1986; 80:429-34.
15. Folstein MF, Folstein S, McHugh PR. Mini mental state: a practical method for grading the cognitive state of patients for the clinician. *J Psych Res* 1975; 12:189-98.
16. Sheikh JL, Yesavage JA. Geriatric depression scale (GDS). Recent evidence and development of a shorter form. *Clin Gerontologists* 1986; 5:165-73.
17. Jenicke, MA. Assessment and treatment of affective illness in the elderly. *J Ger Psych and Neurology* 1988 1:87-107.
18. Buchsbaum DG, Buchanan RG, Centor RM, et al. Screening for alcohol abuse using CAGE scores and Likkehead ratios. *Ann Int Med* 1991; 115:774-77.
19. Falling—the unexpected trip. *A Safety Program for Older Adults, Program Leaders Guide*. U.S. National Safety Council and the American Association of Retired Persons, 1982.
20. Rubenstein LZ, Shock AE, Wieland D. Impact of geriatric evaluation and management programs on defined outcomes: overview of the evidence. *J Am Ger Soc* (Suppl) 1991; 39:85-165.
21. DeVore PA. Computer assisted comprehensive geriatric assessment in a family physician's office. *Southern Med J* 1991; 89:953-55.
22. Williamson J, Stokoe IM, Gray S, et al. Old people at home, their unreported needs. *Lancet* 1964; 1:1117-20.
23. Tulloch AH, Moore V. A randomized controlled trial of geriatric screening and surveillance in general practice. *JR Coll Gen Pract* 1979; 29:733-42.
24. Lowther CP, MacLeod RDM, Williamson J. Evaluation of early diagnostic services for the elderly. *BR Med J* 1970; 3:275-77.
25. Williams, ME, Williams TF, Zimmer JG, et al. How does the team approach to outpatient geriatric evaluations compare with traditional care: a report of a randomized control trial. *J Am Ger Soc* 1987; 35:1071-78.
26. Veiter NJ, Jones DA, Victor CR. Effects of health visitors working with elderly patients in general practice: a randomized controlled trial. *BR Med J* 1984; 288:369-72.

27. Reifler RV, Eisdorfer C. A clinic for impaired elderly and their families, *Am J Psych.*, 1980, 137-1399-1403.
28. Applegate WB, Akins, D, Vandert Swaag R. A geriatric rehabilitation and assessment unit in a community hospital. *J Am Ger Soc* 1983; 31:206-10.
29. Rubenstein LZ, Josephson ER, Weiland GD, et al. Effectiveness of a geriatric evaluation unit: a randomized clinical trial. *N England J Med* 1987; 311:1664-70.
30. Thomas DR, Brakan R, Haywood BP. Inpatient community based geriatric assessment reduces subsequent mortality, *J Amer Ger Soc* 1993; 41:101-4. ■

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Smoking, age, and sex in carotid artery atherosclerosis: a review of 3,865 carotid duplex scans

Arthur L. Gudwin, M.D. and Constantine J. Padussis, M.D

Dr. Gudwin is chief of vascular surgery at North Arundel Hospital. Both authors are clinical assistant professors of surgery, University of Maryland.

ABSTRACT: *The association of smoking with atherosclerotic disease is widely accepted, but inadequate recording of smoking histories lead to a wide range of reported correlations with this important risk factor. Additionally, there has been a controversial concept that smoking causes atherosclerosis in men to a greater degree than in women.*

In this study, carotid duplex scans (CDS) were performed on 3,865 referred patients who gave reliable smoking histories. Participants who had smoked for ten years or more were classified as "smokers" regardless of their present status. The finding of significant plaque (over 50% stenosis) was compared in smokers and nonsmokers at all ages and for both sexes. The findings in almost 4,000 patients referred for carotid duplex scans are presented and show that smoking is a potent risk factor in carotid artery arteriosclerosis. Both men and women are equally affected.

The association of tobacco smoking with atherosclerosis obliterans of the carotid and other arteries is generally accepted, yet the degree of this correlation differs in various studies.^{1,2} Additionally, there has been a controversial concept that smoking is less harmful to women than to men, with some earlier reports suggesting that significant carotid artery stenosis is twice as prevalent in males.³ The carotid duplex scan (CDS) has become well established during the past 10 years and offers a unique window into the arterial system, allowing large population samples to be accumulated to evaluate questions related to the association of tobacco and carotid artery atherosclerosis.⁴

Methods

From 1983 to 1991, the authors performed carotid duplex scans on over 7,000 patients at North Arundel Hospital in Glen Burnie, Maryland. Patients

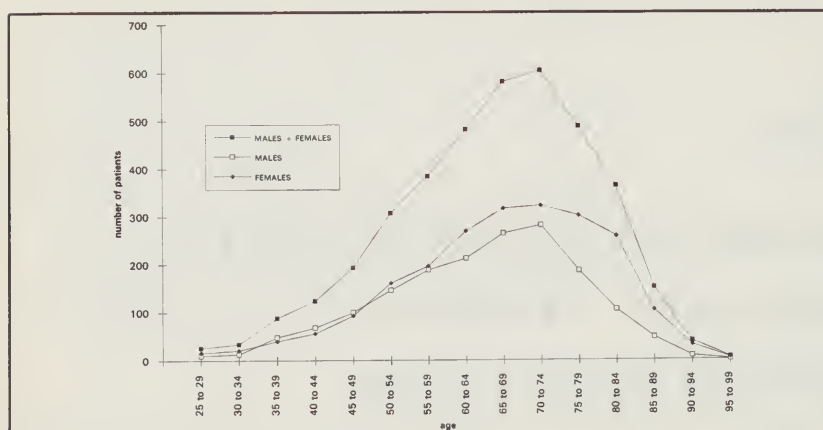


Figure 1. The distribution of all patients by sex and five-year age groups.

were referred for various reasons, such as fainting, visual disturbances, dizziness, confusion, memory impairment, falling, bruits, transient ischemic attacks, and stroke. Approximately 90% of the subjects were inpatients. Fewer than 5% presented with strokes or other lateralized neurologic symptoms. They were probably typical of the population being referred for CDS.

By being present during the history taking as well as for the entire examination, the authors repeatedly observed that “ex-smokers” were quick to consider themselves “nonsmokers.” Initially, there was no intent to report this data, therefore many of the histories were not recorded and data was inaccurate for more than 3,000 patients. As the sample size expanded, efforts to collect this data were increased, and 3,865 records with reliable smoking histories were obtained or verified by the authors.

The 3,865 patient records were entered into a computer database program designed to accept the parameters of age, sex, smoker or nonsmoker, and severity of atherosclerotic plaque. Anyone who had smoked for ten years or more was considered a “smoker,” whatever the individual’s present smoking status. Patients under age twenty-five were excluded since the young-

est smokers would probably not have the ten year requirement. Those who had smoked less than ten years were not included in either the smoker or nonsmoker groups.

The severity of plaque was expressed as follows: Normal=no plaque seen; Minimal=under 25% stenosis; Moderate=25-50% stenosis; Advanced=over 50% stenosis.

The database program counted the number of records for a variety of conditions such as the number of male and/or female smokers, or nonsmokers in a sequence of five year age groups, and was used to record the severity of atherosclerotic plaque.

Results

There were 1,677 males (43.4%) and 2,188 females (56.6%). The distribution of the entire population by five year age groups and sex is shown in **Figure 1**. Sixty-five percent of the patients had been smokers for at least ten years although considerably fewer of the subjects were currently smokers (approximately 30%). Of the males, 82% were or had been smokers compared to 52% of the females. Advanced plaques were found in 729 of the 3,865 patients (18.8%).

Analysis of this population of patients who were being evaluated for possible carotid artery disease showed that advanced plaque formation was primarily a disease of smokers until the age of seventy. **Figure 2** shows the striking difference in the prevalence of advanced plaques in smokers and nonsmokers. Statistical analysis showed that in the six age categories from fifty-five to eighty-four years, the percent differences in the occurrence of advanced plaques between smokers and nonsmokers were significant ($p < 0.001$) using the Chi-Square and/or Fisher’s Exact Test.

There were no advanced plaques found in the first three age groups (age twenty-five to thirty-nine) which totaled 148 patients. In the forty to forty-four year age group advanced plaques were found in 3 of the 83 smokers and in none of the 41 nonsmokers. In the forty-five to forty-nine year age groups, advanced plaques were seen in 7 of the 144 smokers and none in the 49 nonsmokers. In the fifty to fifty-four year age group, 17 of the 232 smokers and 2 of the 75 nonsmokers showed advanced plaques, but in these three age categories, and in the three age groups above age eighty-four, statistical significance was not achieved. It was rare to find advanced plaques in nonsmokers under age sixty (1% compared to 8.3% of smokers), and this difference was significant ($p < 0.001$). From ages sixty to sixty-nine, the incidence was 8% in nonsmokers (12/272) and 23% in smokers (184/

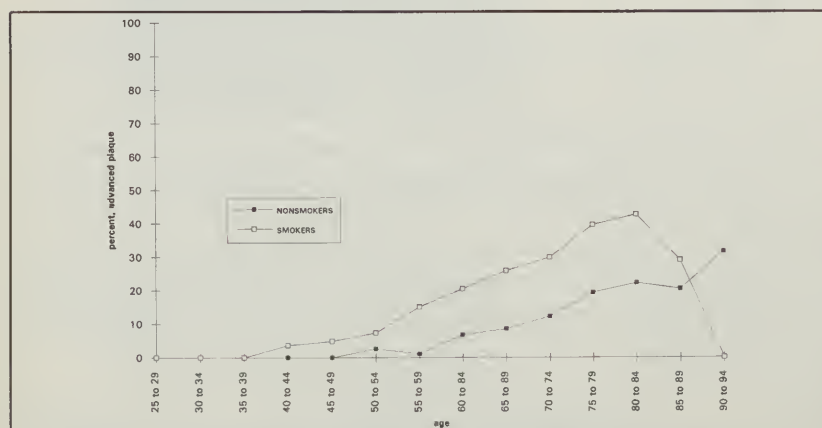


Figure 2. A comparison of smokers and nonsmokers for the incidence of advanced atherosclerotic carotid artery plaques.

789), and these percentages differ significantly ($p<0.001$). The majority of the advanced plaques occurred before age seventy-five (58%), and of these, 88% were in smokers. By age seventy-five, large numbers of positive tests accumulated in the nonsmokers. At ages seventy-five to seventy-nine, the incidence was 19% in nonsmokers, but was twice as frequent (38.4%) in the smokers, and this difference was significant ($p<0.001$).

There were no significant percentage differences between males and females in the incidence of advanced atherosclerotic plaque in smokers and in nonsmokers (Figures 3a and 3b). In no age category did the incidence of advanced plaques differ significantly between males and females at the $p<0.05$ level of probability for either the smoker or nonsmoker groups. Even if the smoking history is disregarded, advanced disease was found only 4% to 7% more frequently in men (Figure 4).

Discussion

The pathogenesis of atherosclerosis is still not fully understood. Earlier studies on autopsy findings emphasized the fatty streaks found in the vessels of young accident victims. Some have speculated that smoking is harmful to arteries only in the presence of hyperlipidemia.^{5,6}

More recent reviews support the theory that the process starts as an intimal injury and inflammatory reaction.⁷ Laboratory studies have shown smoking to cause direct injury to endothelium and vessel walls, as well as changes in blood viscosity, lipids, and coagulation. Inflammation is found as infiltration of macrophages and monocytes in the arterial intima of early plaques.⁸ Hyperemia and fibrosis of the adventitia and

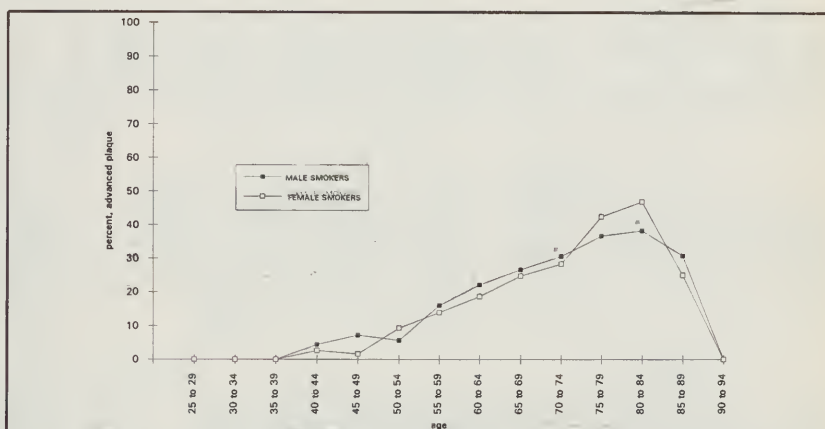
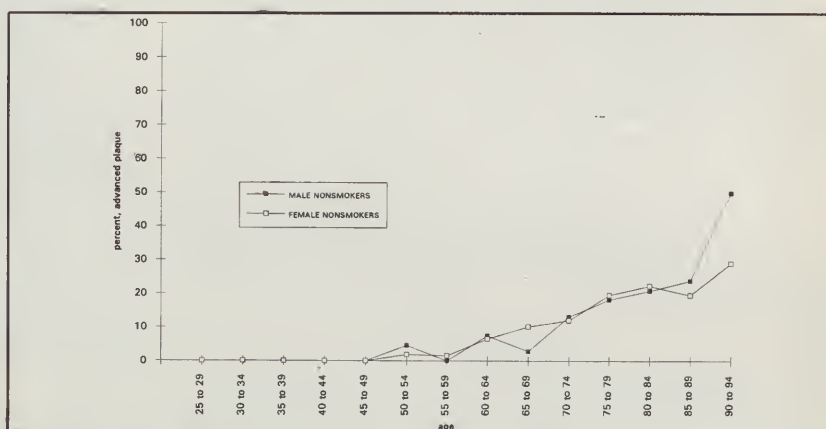


Figure 3(a,b). A comparison of males and females for the incidence of advanced atherosclerotic carotid plaques in smokers (3a) and nonsmokers (3b).



perivascular tissue is commonly observed when operating on carotid and other arteries. These inflamed-appearing areas are in the same location as the plaques within. Prolonged exposure to the various organic substances in tobacco smoke could provide chemical injury that causes inflammation. The subsequent plaque formation is the end result of the process.

Almost nine out of ten of patients under the age of seventy-five with advanced plaque were smokers in the present series. This suggests the primacy of smoking as a cause of atherosclerosis rather than as simply another of many possible risk factors. In addition, the prevalence of smoking in this (probably typical) population would make the smoking history difficult to factor out in the evaluation of other causes. Only 18% of males and 48% of females had never been smokers, for an average of 38% of the total number.

Estimation of the dose range of smoke exposure in terms of "pack-years" and the possible effect of the cessation of smoking was not addressed, yet marked prevalence of advanced atherosclerotic plaque was shown in this broadly

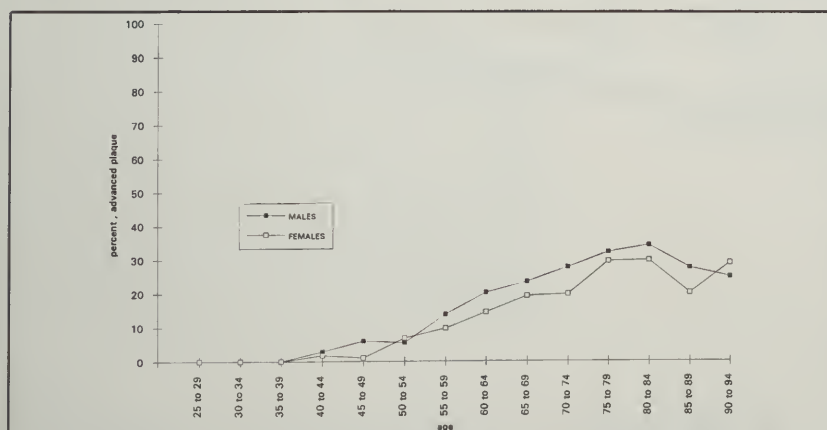


Figure 4. The incidence of advanced plaque formation in males and females regardless of smoking history. The incidence was approximately 4% to 7% higher in males. This difference is not seen when the smoking history is considered (Figure 3).

defined population of smokers. Studies have shown that the risk of coronary artery disease in ex-smokers diminishes to that of nonsmokers ten years after cessation, but the behavior of carotid disease in ex-smokers is still unknown.⁹ Other risk factors thought to be synergistic with smoking in atherogenesis were not evaluated, but others have shown no difference in the occurrence of diabetes, hypertension, and hyperlipidemia in smokers and nonsmokers.^{9,10} It seems reasonable to assume that the occurrence of these conditions would also be equally distributed between the smokers and nonsmokers in this large population sample.

At age seventy-five and above, many nonsmokers were found to have advanced plaques, however the frequency of plaques in this group was only half the rate of the smokers. One theory is that these plaques resulted from the exposure to secondary smoke. Since an astounding 82% of the males had a significant smoking history, it is probable that a great many of the female nonsmokers had lived with smokers. Human studies have shown that smoking markedly increases the desquamation of endothelial cells and this effect has also been found in "passive" smokers.^{11,12} Future studies could be designed to provide data for the smoking history of spouses. For the present, it is tempting to speculate some role for "secondary smoking."

Summary

Smoking histories were obtained during carotid duplex scan examinations in 3,865 patients who were being screened for atherosclerotic disease of the carotid bifurcation. Over half of the patients initially claiming to be "nonsmokers" admitted to significant smoking in their past. Advanced atherosclerotic plaques were found in 729 patients (19% of the total). Of the advanced plaque patients under age seventy-five, 88% were or had been smokers for at least ten years. Below age sixty the correlation was even stronger. In these younger patients smoking seems to act as a prerequisite to the development of atherosclerotic carotid plaques. At all ages, men and women were equally affected by smoking. The possible role of "secondary smoking" as a risk factor in the development of atherosclerotic plaques in elderly nonsmokers is discussed.

References

1. Lakier JB. Smoking and cardiovascular disease. *Am J Med* 1992; 93(1A):8S-12S.
2. Lee CS, Sario J, Matsumoto T. Changing patterns in the predisposition for amputation of the lower extremities. *Am Surg* 1992; 58(8):474-7.
3. Caplan LR, Gorelick PB, Hier DB. Race, sex and occlusive cerebrovascular disease: a review. *Stroke* 1986; 17:648-55.
4. Caplan LR. Carotid artery disease. Editorial. *N Engl J Med* 1986; 886-88.
5. McGill HC. The cardiovascular pathology of smoking. *Am Heart J* 1988; 115:250-57.
6. Criqui MH. Epidemiology of atherosclerosis: an updated overview. *Am J Cardiol* 1986; 57:18C-23C.
7. Krupinski WC. The peripheral vascular consequences of smoking. *Ann Vasc Surg* 1991; 5:291-304.
8. Ross R. The pathogenesis of atherosclerosis—an update. *N Engl J Med* 1986; 314:488-500.
9. Tell GS, Howard G, McKinnon WM, Toole JF. Cigarette smoking cessation and extracranial carotid atherosclerosis. *JAMA* 1989; 261:1178-80.
10. Haapanen A, Koskenvuo M, Kaprio J, Kesäniemi YA, Heikkilä K. Carotid arteriosclerosis in identical twins discordant for cigarette smoking. *Circulation* 1989; 80:10-16.
11. Prerovsky I, Hladovec J. Suppression of desquamating effect of smoking on the human endothelium by hydroxyethylrutinosides. *Blood Vessels* 1979; 16:239-41.
12. Davis JW, Shelton L, Wantanabe IS, et al. Passive smoking affects endothelium and platelets. *Arch Intern Med* 1989; 149:386-89.


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THE MARK OF EXCELLENCE

C. Ronald Franks, D.D.S, vies for US Senatorial seat

This is the second in a series of interviews with candidates running for political office. On December 7, 1993, Editor Victor R. Hrehorovich, M.D., met with C. Ronald Franks, D.D.S., who is challenging Senator Paul Sarbanes for a seat in the US Senate. The following is the result of that interview.

Hrehorovich: Your combination of professions is uncommon. How did you become interested first in a medical field and then in politics?

Franks: In college, I considered an art career and a career in coaching. I eventually decided that medicine was the field that would allow me to integrate my interests in the sciences and in art. I graduated from Georgetown University with honors in 1966.

After serving in the US Air Force and as an associate in Annapolis, I established my own dental practice in a rural area on the Eastern Shore where there were no specialists. I became active in the Maryland State Dental Association. In 1977, I served as secretary and as president of the State Board of Dental Examiners. I was also a chief examiner for the Northeast Regional Board of Dentistry from approximately 1979 to 1990.

Although I was quite active in dental politics for many years, I was never really interested in participating in state or local politics. However, in 1990, the state government was growing faster than the rate of inflation. I thought that this was wrong. There's a point at which government becomes too large and invasive. Like most people, I complained for a long time, but didn't get involved until I realized that the views of the people running for public office didn't reflect my views.

For me, the time to make a decisive move came in 1990. I decided to run for public office and was elected to the Maryland House of Delegates from the 36th District.

Hrehorovich: Who encouraged you to become involved in politics?

Franks: My mother had some reservations about my entering politics, but, in general, both my parents were very supportive. I wanted to become involved in the political process because I thought I could make a real difference. But, I did not want to relinquish my dental practice. For approximately two months, I conducted research on the possibility of combining both activities. With the help of just a handful of individuals, I launched my campaign. I'm



Figure 1. C. Ronald Franks, D.D.S.

very glad I made that decision.

As a legislator, I find nothing more sobering than the need to justify myself to my patients at the end of a legislative session. Contact with my patients keeps me from succumbing to the "inside-the-beltway" mentality.

Hrehorovich: What do you think your impact has been in Annapolis?

Franks: I started out as a freshman delegate from the Eastern Shore. During my first year, I was unfamiliar with the jargon, unprepared for the amount of information I was required to digest, and often felt at the mercy of bureaucrats. But, I persevered.

I became one of the principal voices on the Ways and Means Committee, which deals with tax issues. I participated in formulating a balanced budget proposal without tax increases that was submitted by the Republican caucus. It was the first time that such an alternative to the administrative budget had been presented. I was the only freshman delegate included in its creation.

The budget proposal was rejected. But at my suggestion, a bipartisan committee of conservative Democrats and Republicans forged another proposal for a balanced budget without tax increases.

The administration announced a proposed tax increase of \$248 million. As a member of the Ways and Means Committee, I was aware that this was not the whole picture. Components of the tax increase were in various bills dealing with gasoline, personal income, and food, among others. I suggested something that had never been done before. I proposed adding up the various increases to see what the real impact would be on citizens. I tallied all the tax increases in the proposed bills and arrived at a figure of \$948 million—a much larger figure than the administration's estimate of \$248 million. Although this bipartisan budget proposal was summarily dismissed, it showed that balancing the budget in Maryland without crippling programs and without increasing taxes was possible.

My efforts were not appreciated by members of the leadership or by the governor. The next year, the Speaker

of the House removed me from the Ways and Means Committee. I was placed on the Judiciary Committee. The Speaker reinstated me to the Ways and Means Committee after the Republican caucus showed that it was willing to make a floor fight out of the issue. Since that time, I've continued to offer balanced budget proposals.

After doing extensive research during the summer of 1992, I discovered that about \$34 million to \$36 million went toward the support of allocated and funded, but unfilled, personnel positions. The money was being used to raise salaries during a supposed freeze in salary increases, and to buy items such as paper clips, computers, and cars. Although not all the positions I identified were eliminated after I exposed the situation, I was glad to see that the money allocated for the positions was removed from the 1993 budget.

This experience taught me that budgetary funds can be re-appropriated. I believe my research helped get budget language adopted restricting the use of money budgeted for personnel to personnel. There is now more accountability, and I think that is a significant contribution for a delegate.

Hrehorovich: As a fiscal conservative, do you believe that tax increases are driven by an entrenched bureaucracy?

Franks: When I came to Annapolis, I realized that the bureaucracies of the different departments send lobbyists to influence legislators to increase the departments' budgets. They are not private lobbyists nor are they called lobbyists. These are individuals who are sent by the various departments and who are paid by the state. They come to Annapolis, not with the intention of sharing information with legislators, but to lobby for their individual concerns.

Hrehorovich: Aren't there federal and state regulations preventing government workers from lobbying for their interests?

Franks: I'm not familiar with federal law, but on the state level, these individuals are called public relations people. The functions they perform are comparable with those of private lobbyists. They are the conduit between the legislature and the secretaries of the various agencies around the state. They are ubiquitous. They constantly seek opportunities to speak with legislators and try to exert their influence regarding their particular share of the budget. I was amazed at this practice.

Hrehorovich: Are state agencies evaluated to determine their cost-effectiveness?

Franks: State agencies undergo audits by the legislature approximately once every three years. The results of the audits are submitted along with budget requests. The information obtained from the audits helps determine budget

increases and changes. I think audits should be used much more extensively because they help illuminate the fact that many agencies don't use their resources as well as they should. For example, some prefer to cut personnel who deliver services rather than making cuts in management.

A good rule of thumb in public health is not to cut the nurses who are responsible for patient care, but cut the number of people who are authorizing the service and increase the number of people they supervise. I believe in cutting mid-management positions or reducing the number of unfunded positions.

Hrehorovich: What percentage of the funding to state bureaucracies could be cut without really reducing any services to the citizens?

Franks: Several things must take place before the state government can become more efficient. First, all three branches of government must want to streamline the government.

Second, government agencies must be cautioned to maintain the same level of service without the help of new taxes. This will force government agencies to replace centralized control with total quality management.

Finally, legislators must become more aware of what legislation will actually cost the state and where the revenues will come from.

Hrehorovich: Why do the executive branch and the legislative branch of the state government lack the will to control spending?

Franks: Two reasons. One is the quest for reelection. The other is a sincere and genuine belief that the state government makes better decisions than individuals or county governments.

Hrehorovich: You are now throwing your hat in the ring as a candidate for US Senator from Maryland. What prompted this decision?

Franks: My frustration with the direction in which this country is moving prompted my decision. I believe my work, in collaboration with the Republican caucus, has made a difference in Maryland in the last few years. But, I can't help feeling apprehensive about the long-term prognosis for our country.

My parents sincerely believed that every American citizen has the opportunity to be whatever he or she wants to be. I also believe this. I want to leave this opportunity to my grandchildren.

Yet, if government and the national debt continue to increase at today's rate, by the year 2006, all the income tax money generated in the United States will not pay the interest on the debt. Furthermore, an insurmountable debt

is not only a harbinger of skyrocketing inflation, but clearly a threat to our status as a world power. I refuse to stand by and watch these things happen. That is why I have decided to run for the United States Senate.

Hrehorovich: How do you assess your chances?

Franks: Realistically, in a general election against Paul Sarbanes, I would still be regarded as an underdog. But, I don't think Maryland is as liberal a state as many people think. The people of Maryland voted for Paul Tsongas in the last presidential primary because he identified debt and deficit growth as serious national problems. In the general election, 15% of the people voted for Ross Perot. His message was the same as Paul Tsongas'.

My record in Annapolis speaks for itself. People will tend to vote for individuals who supported, while in office, the issues on which they campaigned. They will tend to vote for someone who stood toe-to-toe and nose-to-nose with the Speaker of the House and said: "The numbers aren't right. You've got to be honest. You've got to tell people how much you are really going to tax." If people know these facts, then they will choose the challenger.

Hrehorovich: Some of your studies indicate your chances for victory are greater than you've just implied.

Franks: I don't want to be overly optimistic. Paul Sarbanes' reelection numbers have fallen precipitously. He is down to a low 36%. Usually, the number is about 60% for an incumbent. Paul Sarbanes is an honest person, but he lacks the willingness to work hard. He clings to an "I-never-saw-a-tax-I-didn't-love" mentality. He also refuses to take a firm stand on important issues. I can give you a good example of this.

Paul Sarbanes is the highest ranking member of the Foreign Relations Committee. Yet, when my people contacted his office during the crisis in Somalia, they were told he hadn't formulated a position yet. That is not the mark of a true leader.

Definitive objectives for Somalia were not established by President Clinton. Paul Sarbanes should have urged President Clinton to establish such objectives, but he didn't.

Hrehorovich: Have you marshalled the resources needed to run a successful campaign? What type of support have you obtained?

Franks: People are ready for a change. I have been absolutely overwhelmed with encouragement from many sources and amazed at the number of volunteers willing to work in the campaign. We've already established a headquarters with volunteer staffing. Paul Sarbanes, in his first FEC (Federal Elections Commission) report, indicated he

received 95% of his campaign funds from out of state. My campaign will be a grass roots campaign involving the people of Maryland. No big money or outside backers will be involved.

The campaign's focus now is on raising funds to get the message out as soon as possible. We have received support from various dental and medical communities and from health care providers around the state.

Today, there are 56 attorneys but no health care providers in the US Senate. If we in the health care community want a voice in the Senate—and it is very important for us to have a voice in the Senate—then we will have to step forward and fight for it. Funding is crucial.

Hrehorovich: What sort of opposition do you anticipate in the primary?

Franks: Currently, there are two other individuals who have filed. One is a perennial candidate who wants to return to the gold standard. The other is a person who ran against Ben Cardin in the last election and received 20% of the vote. A female attorney in Montgomery County has also expressed an interest in running.

A career politician, a former senator from Tennessee, is also talking about entering the race. There's a very strong possibility that he will declare his candidacy. As heir to a large candy fortune, he has enormous resources at his disposal. His potential candidacy is of some concern, but I don't believe he can beat Paul Sarbanes because it's one career politician against another. Why should the people of Maryland dance with a new devil when they can dance with the devil they know?

Hrehorovich: How much funding is generally expended by a successful candidate to run a credible campaign?

Franks: About a million dollars for the primaries and between \$2.4 million and \$2.6 million for the general election. Sixty-five percent to 75% of that is spent on the media and on voter contact. The rest of the money is used for polling and running the campaign office. We're speaking now of a bareboned, grass roots campaign.

Hrehorovich: What impact can a representative with a medical background have at the state level and at the national level? What do you think about the increased regulations confronting medical professionals?

Franks: As a medical professional, I am able to serve as a resource for other legislators. Although I am not on the Committee of Environmental Matters, which handles health issues, members from that committee frequently come to me with their questions. Once a bill reaches the floor, I have the opportunity to represent the medical profession in a way that a layperson could not.

On the federal level, medical professionals are not represented in the US Senate. As the owner of a dental practice and as a health care provider, I am very conscious of the need to operate within several sets of regulations. Sensible voices are clearly needed in the development of regulations. Health care agencies respond to US senators because the latter are in the position to influence the future of the former.

Hrehorovich: What are your views concerning health system reform?

Franks: In all fairness to Bill Clinton, he has identified significant issues that need to be addressed in health system reform. We need portability of insurance. We need to do something about preexisting conditions. We need to introduce reforms enabling small businesses to purchase insurance at competitive rates with large businesses. We do have 36 million people who, for various reasons, are uninsured. But the devil is in the details.

I find President Clinton's solutions unacceptable. You don't throw out all that is good in the present health care system so that you can adopt a system that is unproven and untested. New ideas on managed health care, medical IRAs (individual retirement accounts)[which would enable individuals to save money for future medical expenses], and various methods of delivery must be tested on a pilot scale first and only then introduced nationwide. Anything short of this is arrogance.

It's difficult for me to believe that the federal government will be able to operate a medical system more efficiently and with less fraud and waste than private industry.

Hrehorovich: The government has health system experience in the Indian Health Service and the Veterans Administration medical systems. What is your view of the government's success in these areas?

Franks: Medicare and Medicaid are currently responsible for about 40% of the total health care budget. These two programs generate about 60% of the paperwork. I think that answers your question.

Clinton's health system plan is supposed to cut the costs of existing government programs (Medicare and Medicaid). That doesn't make sense to me. Neither does the rhetoric that says the reforms can be implemented without a big bureaucracy.

In reality, several new levels of bureaucracy will be needed to monitor the reforms. These will include a national health board, alliances, a compliance division, and a computer database probably several times larger than the database used by the Social Security Administration.

Also, insurance companies cannot be dispensed with. Money will have to be found for them. Thanks to a whole new bureaucracy, there will be fewer dollars available for the actual delivery of health care than there are today.

Hrehorovich: What do you think the prospects are for the passage of a national health system reform package.

Franks: I think a package will be passed after a protracted debate. One thing people fail to realize is that the proposed package removes the ceiling on social security. The revenues that will be generated by all the "minor changes" to the tax laws will result in an enormous influx of funds directed toward making the health care package work. Consequently, more money will be siphoned from the private sector. In the long run, this cannot benefit the country.

Hrehorovich: At the national level, there are other issues that have become critical in the eyes of the American people. One such issue is crime. What would your solution be to this national dilemma?

Franks: Only two things make people law abiding—the values one receives as a child and the fear of swift, certain punishment. The second is missing in our culture today. People have lost confidence in the justice system. We have to return that confidence. I applaud the President's crime package. But it isn't just a question of putting more police officers on the streets and building more jails. We have to make the system equitable. The punishment for crimes must be predictable. Criminals must learn that they cannot walk in one door and out the other.

Hrehorovich: How can individuals who want to hear more about your views get in touch with you?

Franks: They can write to headquarters, 313 Winchester Creek Road, Grasonville, MD 21638-9741. Or they can call 1-800-3-FRANKS.

Edited by Olya Samilenko, associate professor, Goucher College, Towson, Maryland. ■

Upcoming issues of the *MMJ* will feature other candidates for political office. Inclusion of interviews with political candidates does not necessarily indicate support or endorsement. Any candidate wishing to be considered for an interview by the *MMJ* should contact the journal office at 410-539-0872 or 800-492-1056.

WORD ROUNDS

Bart Gershen, M.D.

"Maryland! My Maryland!"

In 1849, the British ship **Herald** sailed north along the western coast of Alaska. Its mission was to chart the waters and identify prominent landmarks. At 64° north latitude and 165° west longitude, the cartographer on board observed a large peninsula jutting into the Chukchi Sea. Finding no reference to it on any map, he scribbled "Cape ? Name" onto his sketch of the region. When his penciled chart was being completed for publication, the editor could not quite read the smudged label. Therefore, the printed map bore the emblem "**Cape Nome.**"

In September 1898, gold was discovered in Anvil Creek, a narrow river flowing south across Cape Nome. The rush was on. Within several months, a town had developed on the banks of the stream. The residents named it Anvil City. Its population soared to 20,000. However, after the gold had vanished, the people disappeared as well, and the population dropped to 850 citizens. They changed the name of the town. Today it is called **Nome, Alaska**—a name founded on a printer's error.

The naming of American towns, villages, and cities makes fascinating study. Many names are derived from the language of the indigenous Americans native to a particular region—such as **Des Moines**, Iowa, which is named for the **Moingona** Indian tribe (French *des Moingon* 'of the Moingona'). **Appomattox**, Virginia was named for a tribe of the Powhatan Indians, **Pawtucket**, Rhode Island was named by the Narragansett tribe (it means "falls of water"); **Waco**,

Texas, was named for the Waco Indians; **Sheboygan**, Wisconsin, was named by the Potawatami tribe (it means "rumbling waters"); **Kalamazoo**, Michigan, is Potawatami for "where the waters boil"; and **Chicago**, Illinois, which is Algonquin for "onion or garlic smell," a reference to nearby fields of wild onions. In addition, states such as **Nebraska**, **Mississippi**, **Connecticut**, **Alabama**, **Arkansas**, **the Dakotas**, **Ohio**, and **Oregon** derive their names from Native American words. In fact, from **Narragansett** to **Napa**, our geography is richly endowed with the language and imagery of our original citizens.

On the other hand, many settlements were named for exceptional people who had explored the region, pioneered its colonization, or were selected for special recognition. **Dallas**, Texas, is named for **George Mifflin Dallas**, who was vice-president of the United States under James Knox Polk. **New York City** and **Yorktown**, Virginia, are named for the son of King James I of England, the **Duke of York**, who later reigned as Charles I. (Unfortunately, he also presided over the English civil war and, ultimately, lost his head over it in 1649—but not before granting charter to the colony of Maryland.) **Albany** is named for **James, Duke of Albany**, who later reigned as James II of England.

Other eponymic communities come quickly to mind—**Denver**, Colorado; **Charlotte**, North Carolina; **Cleveland**, Ohio; and **Houston**, Texas—to name just a few. However, I believe the state that is

the mother of all eponyms is Maryland. It also excels in titular nepotism, as witness the plethora of names generated by our founding family.

For 16 years, George Calvert was a member of the English House of Commons, a secretary of state, and a member of the Privy Council. He resigned those positions in 1625, after he had converted to Roman Catholicism. (England's state religion was Anglican by this time.) Shortly thereafter, James I created a peerage for Calvert, and Calvert became known as **Baron Baltimore of Baltimore** with vast holdings in Ireland. He established a colony in Newfoundland, which he christened Avalon. Unfortunately, the foul weather obliged him to petition King Charles I for another land grant—one in a milder climate.

George Calvert died in 1632 before this request was honored. The charter of Maryland thus passed to his eldest son Cecilius (Cecil), the second Lord Baltimore. In 1634, Leonard Calvert, Cecil's younger brother, landed on Blakiston Island at the lower end of the Potomac River. This area is now St. Mary's County. Its county seat, **Leonardtown**, is named for **Leonard Calvert**, who became the first governor of the colony.

Obviously, **Baltimore County** and **Baltimore City** were named for the Lords Baltimore. **Anne Arundel County** is named for Cecil Calvert's wife, **Anne Arundell**. Its county seat is **Annapolis**—Anne's city (Greek *polis* 'city')—which simultaneously serves as the state capital.

Calvert and **Cecil counties** are easily identifiable eponyms. **Charles County** is named for Cecil Calvert and

Anne Arundell's son **Charles**, who was the third Lord Baltimore. **La Plata**—the county seat of Charles County—may have been named for silver mines that some thought were located there (Spanish *plata* 'silver'). **Worcester County** is named for **Edward Somerset, sixth Earl of Worcester**, who was George Calvert's son-in-law. **Somerset County** is also named for him.

Dorchester County is named for Richard Sackville II, **fifth Earl of Dorset**, who was a close friend of the Calvert family. (Words ending in "caster," as in Lancaster, or in "chester," as in Manchester, derive from Latin *castrum* 'fort or camp'. Thus, **Dorchester** means "**Dorset's encampment**.")

Caroline County is named for **Caroline Calvert**, sister of Frederick Calvert, sixth Lord Baltimore. **Harford County** is named for **Henry Harford**, his illegitimate son. **Frederick County** and its county seat are each named for **Frederick Calvert**, who also finds some distinction as the last proprietor of the Maryland colony.

Regal eponyms also flourish within our otherwise unpretentious state. **Queen Anne's**, **Prince George's**, and **Kent counties** derive their names respectively, from England's **Queen Anne** (1702-1714), her husband-consort **Prince George of Denmark**, and Edward Augustus, the **Duke of Kent** (Queen Victoria's father). And, of course, our state name derives from Queen Henrietta Maria, wife of King Charles I.

Three counties bear tribute to revolutionary war heroes. **Montgomery County** honors **General Richard**

Montgomery who was born, appropriately enough, in Swords, County Dublin, Ireland. In 1773, he emigrated to America and, at the outbreak of the American Revolution, was appointed brigadier-general of the Continental army. In November 1775, he commanded the expedition that captured Montreal. One month later, he was killed during the invasion of Quebec.

Bordering the northeastern perimeter of Montgomery County lies **Howard County**, named for **John Eager Howard**, soldier of the Continental army, member of the Continental Congress, governor of Maryland, and member of the United States Senate. Adjacent to Howard County lies **Carroll County**, named for **Charles Carroll**, member of the Continental Congress and a United States Senator. He was one of four Marylanders who signed the Declaration of Independence, penning the words "Charles Carroll of Carrollton." He was also a founder of the Baltimore and Ohio Railroad.

Two other counties deserve eponymic recognition. **Washington County** surely requires no explanation. **Garrett County**, however, may be less readily identified. It is named for **John Work Garrett**, an industrialist and the president of the Baltimore and Ohio Railroad from 1858 to 1884.

There are two additional counties in Maryland that do not owe their titles to the Calverts, or to royalty, or to American heroes, or to the captains of industry. They are **Wicomico** and **Allegany**, both of which are obligated to the original Americans from whom we have taken so much.

Finally, we return to the original community established by Leonard

Calvert. The county we know as **St. Mary's**, named for the **Virgin Mary**, by those early colonists—people who had come to this new land seeking religious freedom and who were driven from their native England by prejudice and cruelty.

They sought spiritual independence for all religions.

They found it in the new colony of Maryland.

Sometimes, we forget that.

Suggested readings

Harder, Kelsie B (ed). *Illustrated Dictionary of Place Names*. New York: Van Nostrand Reinhold. 1976

Stewart, George R. *American Place-Names: A Concise and Selective Dictionary for the Continental United States of America*. New York: Oxford University Press. 1970.

Sween, Jane C. *Montgomery County: Two Centuries of Change*. Windsor,

New York: Windsor Publishing Corporation. 1984.

Webster's New Biographical Dictionary. Merriam-Webster, Inc. 1988.

Wolk, Allan. *The Naming of America*. Nashville, Tennessee: Thomas Nelson, Inc. Publishers. 1977. ■

The *Maryland Medical Journal* is the official publication of the Medical and Chirurgical Faculty of Maryland. It exists to serve Med Chi members' needs. The editorial board encourages members' participation, input, suggestions, and criticisms through submission of

- Original research, case studies, and review articles
- Essays on medical history in Maryland
- Updates on members' promotions, nominations, awards, and honors for inclusion in "Members in the News"
- Obituary information on Med Chi members for "In Memoriam"
- News of continuing medical education activities in Maryland for listing in "CME Programs"
- Opinions, questions, or thoughts about all aspects of medicine for "Letters to the Editor" and "Speak Out"
- Questions for "A Moment with Endocrinology and Metabolism"
- Radiologic puzzles for "Imaging Case of the Month"

The Hospital Medical Staff Section 23rd Assembly Meeting June 9-13, 1994 Chicago Marriott Hotel Chicago, Illinois

Interactive Dialogue with AMA Board of Trustees

HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform

With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement ; and
- expands the role and protection for the profession's accreditation, standard setting and medical society disciplinary functions.

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Book Reviews

Gender Issues in the Workplace: A Guide for Physician Executives

Sim Tan, M.D., F.A.C.P.E. (ed). Tampa, Florida: American College of Physician Executives. 1991. 100 pages. \$25.95 (paper).

This monograph on gender roles had its beginning with the "Forum on Women in Medicine and Management" sponsored by the American College of Physician Executives. The book's purpose is to help men and women physician managers understand the similarities and differences between male and female physician leadership.

A dozen authors contributed to this book of eight brief chapters that are easy to read and list references for further exploration. The first five chapters cover issues such as communication style and its importance to patient compliance and choice of medical specialty, and the significance and prevention of physician turnover in an organization. Chapters 6 through 8 address human resource issues such as equal employment opportunity laws, performance appraisals, terminations, sexual harassment, maternity leave, child care, and shared positions. These chapters also provide recommendations to help managers in health care settings.

There is a list of lawful versus unlawful questions that job applicants may be asked and an assessment tool to evaluate gender awareness concerning financial and lifestyle issues.

The face of American medicine is changing as the number and percentage of women physicians increase. Likewise, the leadership scene at the top of management is changing as more men and women find themselves reporting to female doctors.

The articles in this monograph propose that the male approach and the female approach to communication and management are different and, depending on the circumstances, can be used effectively by both men and women. This book would be valuable reading for anyone who wants to gain the maximum benefit from the different leadership styles of women and men.

MARILYN S. RADKE, M.D., M.P.H.
Waldorf, Maryland ■

Epidemiology of Congenital Heart Disease: The Baltimore-Washington Infant Study 1981-1989 (Perspectives in Pediatric Cardiology. Volume 4). Ferencz C, Rubin JD, Loffredo CA, Magee CA (eds). Mount Kisco, New York: Futura Publishing Company. 1993. 353 pages. \$75.00

Cardiovascular congenital malformations contribute a disproportionate excess to infant deaths in developed countries and cause significant medical, psychosocial, and economic consequences. In the United States, it is estimated that congenital heart disease contributes to almost one-half of all deaths due to congenital anomalies. The need to predict and prevent congenital heart disease and to provide prenatal counseling requires a knowledge of possible risk factors. Epidemi-

ologic studies that search for risk factors, such as the study described in this book, will provide the clinical and medical care information that cannot be obtained at the bedside.

A group of investigators from the University of Maryland School of Medicine, with a grant from the National Heart, Lung and Blood Institute, embarked on the first population-based etiologic study of congenital heart disease. This extensive study was conducted in the Baltimore-Washington area with the collabo-

ration of pediatric cardiology centers, area hospitals, and local practicing physicians. Socio-demographic and medical/obstetric data, as well as data on exposure to potentially harmful substances, lifestyles, medical therapies, and in home and occupational activities, were recorded, providing a wealth of information.

The book provides detailed tables and figures. It is a well-organized book written by several expert contributors. They present an overview of the distribution of congenital heart disease in a defined popu-

lation and the characteristics that represent potential risk factors. They then explore the genetic and environmental components of congenital anomalies. They also identify teratologic and methodologic issues that future studies of congenital heart disease must address. The book should be of great interest to epidemiologists, geneticists, and pediatric cardiologists.

The authors state that, "clearly neither in our data nor in those of other epidemiologic studies, do apparent associations represent causes or even risk

factors; at most, they become candidate hypotheses after appropriate statistical analyses and detailed evaluations of biological features." The investigators are continuing their studies under a new grant. They should be congratulated for their perseverance so that, eventually, the prevention of congenital heart disease may become a reality.

CHRIS PAPADOPOULOS, M.D., FACC
Baltimore, Maryland ■

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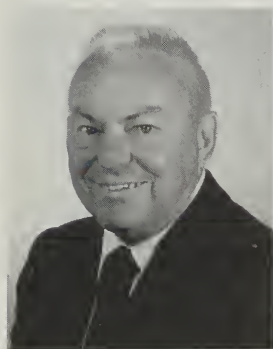
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Members in the News



FRANK J. AYD, JR., M.D., L.F.A.P.A., professor of psychiatry at West Virginia University Medical Center and emeritus director of professional education and research at Taylor Manor Hospital, was recently awarded the Distinguished Service Award of the American College of Neuropsychopharmacology—he is

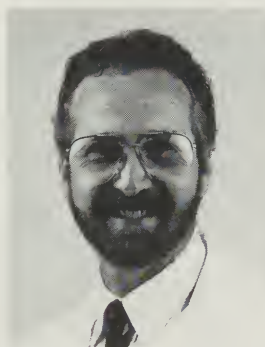
only the third recipient of this honor. A graduate of the University of Maryland School of Medicine, Dr. Ayd was certified a diplomate in psychiatry in 1951. Dr. Ayd, who has lectured all over the world, is a member of the National Association of Science Writers, Inc.; is editor of the *International Drug Therapy Newsletter* and the *Medical-Moral Newsletter*; has authored *Recognizing the Depressed Patient* as well as more than 350 scientific articles; and has served as editor or coeditor for more than 10 books. His numerous honors and awards include the Holy Name Society Award for Outstanding Service to Church and Community (1960); the American Medical Writers Association Award (1975); an honorary doctor of science degree from Stonehill College, Massachusetts; four honorary doctor of law degrees; the Open Mind Award in Psychiatry from the Janssen Research Council of Belgium (1988); the Paul Hoch Distinguished Service Award from the American College of Neuropsychopharmacology (1988); and, in 1987, Taylor Manor Hospital honored Dr. Ayd by naming its library the Ayd Professional Library.



BAYANI BORJA ELMA, M.D., an internist in Baltimore, was recently awarded membership in the American College of Physician Executives, the nation's only educational and professional organization for physicians in medical management. A graduate of the University of the Philippines and the

University of the East, both of which are in Quezon City, Philippines, Dr. Elma serves as director and trustee for Maryland General Hospital in Baltimore—a hospital with which he has been affiliated for 24 years. Dr. Elma is president of the University of the East Medical Alumni

Association of America, Inc., and editor-in-chief of its *Alumni Newsletter*. In addition, he is a member of the Maryland Commission on Asian-Pacific American Affairs, having been appointed by Governor William Donald Schaefer. Dr. Elma, who is frequently asked to write material on the Philippines, is also a member of the editorial board of the *Maryland Medical Journal*.



KEVIN SCOTT FERENTZ, M.D., a family practitioner, was recently appointed director of the Family Practice Residency at the University of Maryland Hospital. A native of New York, Dr. Ferentz is a graduate of the State University of New York at Albany and the School of Medicine of the State

University of New York at Buffalo. He completed a residency in family medicine at the University of Maryland and fellowships in faculty development at the University of Maryland Hospital and in obstetrics at St. Agnes Hospital. An associate professor, Dr. Ferentz is a regular co-host of the nationally syndicated medical call-in show, "Sunday Rounds"—produced for public radio in conjunction with the American Academy of Family Physicians. Billed as "the bravest man in the world" because he'll take questions on any subject, Dr. Ferentz is introduced with music from *Superman* or *Indiana Jones*. Married with three sons, Dr. Ferentz is an active member of the Maryland Academy of Family Physicians, currently serving as treasurer, and of Med Chi, currently serving on the Editorial Board of the *Maryland Medical Journal*, the Committee on Scientific Activity, and the Committee on Focused Professional Education.

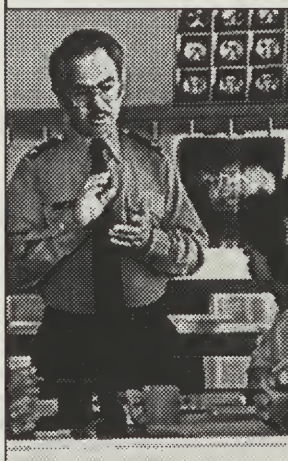


ADMIRAL HENRY P. LAUGHLIN, M.D., Sc.D., Sc.S.D., a psychiatrist in Frederick County, recently received the governor's salute to excellence from Governor William Donald Schaefer of Maryland. This honor was bestowed for Dr. Laughlin's "...impressive commitment to the people of Maryland...as

demonstrated by [his] outstanding contributions as a

medical author, as well as [his] distinguished record of community service...." Author of a score of textbooks and more than 12 dozen articles over the past 45 years, Dr. Laughlin has long been active in the Sons of the American Revolution (SAR), serving as inaugural president of the Council of Presidents of the Maryland SAR, state SAR president, and national SAR surgeon general. He was also elected the honorary life president of the Sgt. Lawrence Everhart Chapter, SAR of Frederick County. A longtime supporter of organized medicine, Dr. Laughlin has served as president of the Montgomery County Medical Society and the Frederick County Medical Society, as well as being active on numerous Med Chi committees, including serving as associate editor of the *Maryland Medical Journal*.

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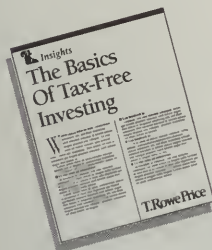
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| Tax-free fund | \$912 | – | \$0 | = | \$912 |
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| Tax-free fund | \$664 | – | \$0 | = | \$664 |

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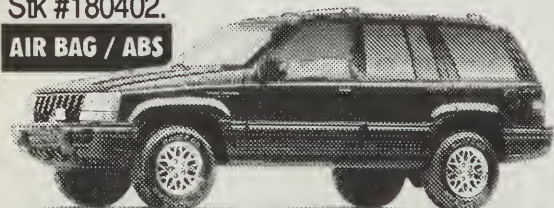
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Medical Miscellany

Doctors in Annapolis

Med Chi physicians gathered for "Doctors' Day in Annapolis" on February 17, 1994, in an effort to increase the communication between the medical community and Maryland's legislative representatives. The afternoon began with a short legislative briefing by Hilary T. O'Herlihy, M.D., Legislative Committee chairperson, and Med Chi lobbyist Jay Schwartz in the Joint Hearing Room of the Legislative Services Building.

Mr. Schwartz discussed in detail several bills of importance to the profession of medicine. He described three bills regarding the judgments on limitations for noneconomic damages, two of which are supported by Med Chi and one that is opposed. He explained in depth the Health Care Patient Access Act, Senate Bill 472 and House Bill 691, both of which are supported by Med Chi. Mr. Schwartz also discussed several bills on ambulatory care facilities and major medical equipment, all of which are opposed by Med Chi.



Med Chi physicians gathered in the Joint Hearing Room of the Legislative Services Building for "Doctor's Day in Annapolis," February 17, 1994.

After the briefing, physicians met by appointment with legislators to discuss their mutual interest in the quality of care for Maryland's citizens. ■

Physicians and attorneys attend training session

The Baltimore City Doctor/Lawyer/Teacher Partnership Against Drugs held its annual training session on Tuesday, February 1, 1994, in the Med Chi Faculty building. Hiroshi Nakazawa, M.D., Med Chi coordinator for the Doctor/Lawyer/Teacher Partnership Against Drugs, and chairperson, Med Chi Public Relations Committee, welcomed the 15 physicians and the 22 lawyers who attended the training session.

Valerie L. Siegel, Esq., project director, Doctor/Lawyer Education Partnership of the Maryland State Bar Association, discussed the purpose of the program, statewide efforts, and recent developments made possible by a state grant. Ms. Reba Bullock, health education specialist, Baltimore City Schools, educated the group about what it feels like to be a middle school student in the 1990s, why students might begin using drugs, and, most importantly, how this program can keep them from beginning to use drugs. The Honorable Jamey Hochberg Weitzman, chairperson, Doctor/Lawyer/Teacher Partnership Program, Maryland State Bar Association, provided a substantive review. She showed the group how to get students involved in the discussion and keep students focused on the topic.



Valerie L. Siegel, Esq., project director, and Hiroshi Nakazawa, M.D., statewide coordinator, address physicians and lawyers at the MD/JD training session held February 1, 1994.

Following the group presentation, physicians and lawyers broke into groups for profession-specific instruction. Judge Weitzman addressed the lawyers, and Andrew P. Fridberg, M.D., vice-chairperson, Med Chi Public Relations Committee, addressed the physicians.

Visits into the Baltimore City schools will begin in late March or early April 1994. Approximately 10 schools have requested the program, and the Baltimore City Bar Association is working with the school system to encourage more participation. ■

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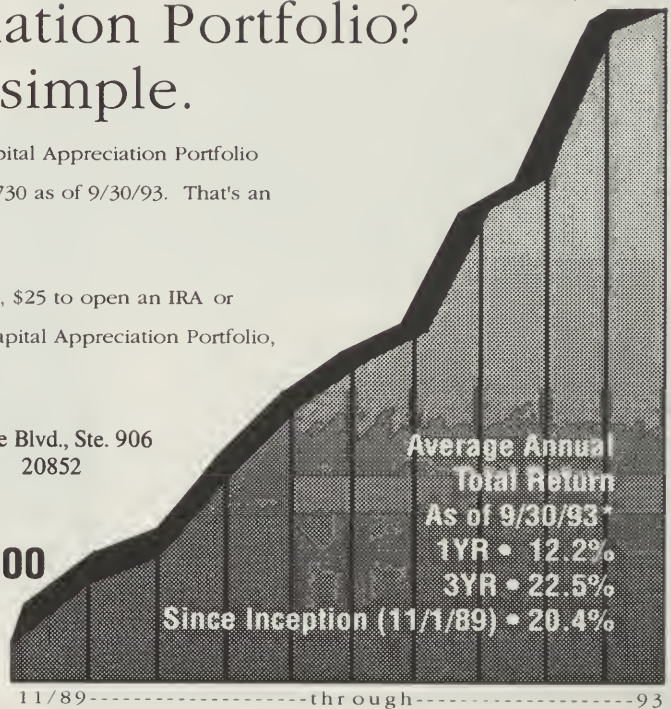
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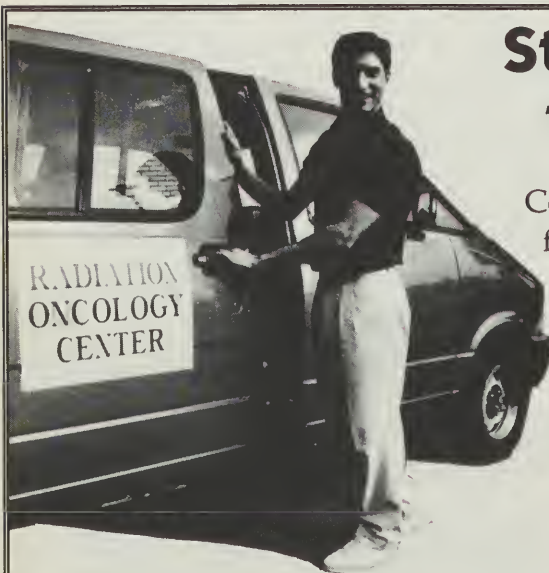
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The Med Chi membership directory is published annually. It lists, by county, the addresses, phone numbers, specialties, board certifications, and specialty society affiliations of all Med Chi members, as well as photographs of Med Chi officers and component society presidents. This update provides the most recent changes.

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Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

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- **Manuscript preparation**—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

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Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

| | |
|---|-------------------|
| Diagnosis and treatment of neoplastic disorders. 14.5 Cat 1 AMA/PRA credits. Fee: \$325 physicians; \$150 residents, fellows, and allied health professionals. | Apr. 7-8 |
| Clinical care of the patient with HIV infection. 13 Cat 1 AMA/PRA credits; 12.75 AAFP credits. Fee: \$325 physicians; \$165 residents, fellows, and allied health professionals. | Apr. 7-8 |
| 21st annual pediatric trends. 41 Cat 1 AMA/PRA credits. Fee: \$650 physicians; \$450 residents and fellows. | Apr. 11-16 |
| Basic concepts in dysphagia diagnosis and management. Cat 1 AMA/PRA credits available. Fee: \$175 physicians; \$100 residents and allied health professionals. | Apr. 13 |
| Fifth multidisciplinary symposium on dysphagia. Cat 1 AMA/PRA credits available. Fee: \$400 physicians; \$225 residents and allied health professionals. | Apr. 14-15 |
| Biological response to orthopaedic implants. 12 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$125 residents and fellows. | Apr. 15-16 |
| Second symposium on the prevention of developmental disabilities in infants and toddlers. 14 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. | Apr. 18-19 |
| International conference on crystalline silica health effects: current state-of-the-art. Fee: \$450. | Apr. 18-20 |
| 35th annual postgraduate institute for pathologists in clinical cytopathology. Course A (home study). Preparation for Course B. | Mar.-Apr. |
| 35th annual postgraduate institute for pathologists in clinical cytopathology. Course B. 136 Cat 1 AMA/PRA credits. | Apr. 18-29 |
| Pediatric allergy and immunology for the practitioner. Cat 1 AMA/PRA credits available. Fee: TBA. | May 5-6 |
| Phototherapy and photochemotherapy. 10 Cat 1 AMA/PRA credits. Fee: \$250 physicians; \$200 nurses and technicians; \$150 residents and fellows. | May 6-7 |
| Optional strategies for treating peripheral vascular disease: a debate. Cat 1 AMA/PRA credits available. Fee: \$25. | May 7 |
| 21st century retina: what's hot, hype, and hard fact. 8 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$100 residents, fellows, and allied health professionals. | June 10 |
| The seventh summer institute on environmental health sciences. Cat 1 AMA/PRA credits available. Infor: Denis Barton, 410-955-3537 or Kay Castle berry, 410-955-2212. | June 6-17 |
| Advanced pediatric life support courses. 20 Cat 1 AMA/PRA credits; 18.5 AAFP prescribed hours; 20 AAP credit hours; 17 ACEP Cat 1 credits. Fee: \$525. | June 13-15 |
| Principles and practices of data management for clinical trials. Cat 1 AMA/PRA credits available. Fee: TBA. | June 16-17 |
| Third annual update on obstetric anesthesia plus an optional fiberoptic airway management workshop. 12 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$75 residents and fellows; one-day fees available. | Aug. 13-14 |

The Johns Hopkins Medical Institutions (continued)

| | |
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| Airway management: hands on workshops, case management colloquia, and difficult airway/intubation alert. Cat 1 AMA/PRA credits available. Fee: \$650. | Sept. 23-25 |
| 20th anniversary: annual topics in gastroenterology and liver disease. Cat 1 AMA/PRA credits available. Fee: \$495 physicians; \$250 residents and fellows (with letter from department chairperson verifying status). | Oct. 5-7 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA/PRA credits available. Fee: \$500 lectures; \$400 each additional lab; \$200 lectures for fellows and allied health professionals. | Oct. 24-26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27-30 |

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- Johns Hopkins sports medicine grand rounds.** Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

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| Managing emergency medical services, at the University of Maryland in Baltimore County. Info: Dr. Richard Bissell, 410-455-3776. | July 5-29 |
| R. Adams Cowley 16th annual national trauma symposium, at the Hyatt Regency, in Baltimore, Maryland. Info: 410-328-2399. | Nov. 16-20 |

Miscellaneous meetings

| | |
|---|-----------------|
| Advanced catheter and surgical ablation for arrhythmias, sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 6-8 |
| Monumental City Medical Society round table discussion, at Liberty Medical Center, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-652-0022. | Apr. 7 |

Miscellaneous meetings (continued)

| | |
|---|-------------------|
| Frontiers in ovulation induction , sponsored by the Washington University School of Medicine, in Philadelphia, Pennsylvania. Info: 800-325-9862. | Apr. 8 |
| Cardiac Pacing , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 11-14 |
| Echo/Doppler applications in coronary artery disease with emphasis on exercise and pharmacological stress echo , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 18-19 |
| Transesophageal echocardiography: demonstration of technique, image orientation, and interpretation of single, biplane, and mutliplane TEE , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 20-22 |
| Clinical psychopharmacology: review and update—1994 , at the Sheppard Pratt Conference Center, in Baltimore, Maryland. 6.25 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. | Apr. 22-23 |
| Nuclear cardiology for the technologist , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 25-27 |
| "Doctor I can't sleep"—a course on insomnia , sponsored by Georgetown University Hospital Sleep Disorders Center, in Washington, DC. 3 Cat 1 AMA/PRA credits. Fee: \$35. Info: Reid C. Blank, 310-288-0466. | Apr. 28 |
| Recent advances in clinical nuclear cardiology , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 301-897-2653. | Apr. 28-30 |
| Federation of state medical boards annual meeting , sponsored by the George Washington University Medical Center, at the Grand Hyatt, in Washington, DC. Info: Maria Gorrick, 202-994-4285. | Apr. 28-30 |
| Pediatric cardiac catheterization update—1994 , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | May 2-4 |
| Challenge of improving health care in the city , sponsored by the Baltimore City Medical Society, at James Lawrence Kernan Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-625-0022. | May 5 |
| Two-dimensional and Dopplet echocardiography for the technologist , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | May 9-11 |
| 46th annual meeting and scientific session , sponsored by the Maryland Academy of Family Physicians, in Ocean City, Maryland. 41.25 Cat 1 AMA/PRA credits; 41.25 AAFP prescribed hours. Fee: \$240 members; \$275 nonmembers; \$135 paramedicals; free for residents, medical students, MAFP retired and life members. Info: Richard Colgan, M.D., 410-747-1980. | May 10-15 |
| Clinical auscultation of the heart , sponsored by the American College of Cardiology, at the Georgetown University Medical Center, in Washington DC. 18 Cat 1 AMA/PRA credits. Info: 301-897-2695. | May 11-13 |

Miscellaneous meetings (continued)

- | | |
|---|-------------------|
| Med Chi's 196th Annual Meeting at the Ramada Inn and Convention Center, in Hagerstown, Maryland. 14 Cat 1 AMA/PRA credits. Fee: Free for Med Chi members. Info: Joan Mannion, 410-539-0872 or 800-492-1056. | May 12-14 |
| Two-D/Doppler and color-flow imaging: a clinical review with emphasis on TEE, stress echocardiography, and Doppler hemodynamics , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | May 12-14 |
| Peripheral artery disease: contemporary strategies for diagnosis and therapy , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | May 18-20 |
| Cardiac transplantation: state-of-the-art , sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. | May 23-25 |
| Modern advances in the treatment of pain , sponsored by the Baltimore City Medical Society, at St. Agnes Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: free. Info: 410-625-0022. | June 2 |
| Obstetrics dilemmas in the era of managed health care , sponsored by the Eastern Virginia Medical School, at the Sheraton Inn Oceanfront, in Virginia Beach, Virginia. Cat 1 AMA/PRA credits available. Info: Jeanette Schmitz, 804-446-6143. | June 3-4 |
| Intensive review of internal medicine , sponsored by the George Washington University Medical Center, at the the Washington Marriott, Washington, DC. Info: Todd Belfield, 202-994-4285. | June 11-14 |
| Second annual board review in family medicine , sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, in Arlington, Virginia. Info: Daniel Reichard, 202-994-4285. | June 11-15 |
| The medical and surgical treatment of macular disorders , sponsored by the University of Maryland School of Medicine and the Retina Institute of Maryland, at the Marriott, in Annapolis, Maryland. 6 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$100 fellows and allied health professionals. Info: 410-337-4500. | June 17 |
| 10th annual meeting of the International Society of Technology Assessment in Health Care , sponsored by the George Washington University Medical Center, at Stouffer Harborplace, Baltimore, Maryland. Info: Maria Gorrick, 202-994-4285. | June 19-22 |
| Twelfth summer symposium in internal medicine , sponsored by the Eastern Virginia Medical School, at the Holiday Day on the Ocean, Virginia Beach, Virginia. 15.5 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$195 resident, nurse, allied health. Info: Ann McClanahan, 804-446-6141. | June 24-26 |
| Annual meeting of the Bolivian Medical Society , sponsored by the George Washington University Medical Center, in Arlington, Virginia. Info: Todd Belfield, 202-994-4285. | Aug. 4-7 |
| Hematology board review course , sponsored by the George Washington University Medical Center, at the Ritz-Carlton, in Pentagon City, Virginia. Info: Maria Gorrick, 202-994-4285. | Oct. |
| Psycho-economics: clinical psychiatry and health care reform in the 1990s , sponsored by the American Psychiatric Association, in Baltimore, Maryland. 34 Cat 1 AMA/PRA credits. Info: 202-682-6174. | Oct. 8-12 |

Miscellaneous meetings (continued)

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, Maryland. Info: 301-279-6115.

| | |
|--|---------|
| Heart burn: update on reflux esophagitis | Apr. 7 |
| Tumor conference | Apr. 14 |
| Current status of gene therapy | Apr. 21 |
| Bioethics | Apr. 28 |
| Ophthalmic plastic and reconstructive surgery | May 5 |
| Tumor conference | May 12 |
| 1993 revised classification system for HIV infection and expanded surveillance; case definition for AIDS | May 19 |
| | June 9 |
| Tumor conference | June 16 |
| Ischemic heart disease | June 23 |
| Current therapy of obesity | June 30 |
| Palliative care across the disease spectrum | July 7 |
| Dermatosis of pregnancy | July 14 |
| Tumor conference | July 28 |
| Recent perinatal advances in the evaluation of the fetus | |



PHYSICIAN'S
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AWARD

During February 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

| | | |
|-------------------------------|------------------------------|-----------------------------|
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| Kenneth Alan Blank, M.D. | Alexander M. Guba, M.D. | James Michael Monihan, M.D. |
| Stephen Paul Crossland, M.D. | Chester Z. Haverback, M.D. | David Shepard O'Brien, M.D. |
| John Sun-Hung Eng, M.D. | A. Victor Khayat, M.D. | Mark Edward Richards, M.D. |
| Joanne Elizabeth Finley, M.D. | Stanley Albert Klatsky, M.D. | Jacob Tendler, M.D. |
| Daniele Fragnul, M.D. | | |

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Ebenezer Israel, MD, MPH - Director
Epidemiology & Disease Control Program

EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

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April, 1994

Identified Surveillance for Vaccine Preventable Diseases

Surveillance for vaccine preventable diseases is a critical component of the national childhood immunization programs. National goals have been established to eliminate by 1996 indigenously acquired cases of six diseases (measles, rubella, *Haemophilus influenzae* type b, diphtheria, poliomyelitis, and tetanus) in some or all age groups; goals for reduction of pertussis, mumps and hepatitis B will be established in 1994. United States and Maryland cumulative cases in 1992 and 1993 (as shown below). In Maryland, pertussis continues to be the most frequently reported childhood vaccine preventable disease.

Number of reported cases* of diseases preventable by routine childhood vaccination -- United States and Maryland 1992-1993

| | Total Cases | | | | No. cases among children aged less than 5 years | | | |
|-----------------------------|-------------|-----|--------|-----|--|----|-------|----|
| | 1992 | | 1993 | | 1992 | | 1993 | |
| Disease | US | MD | US | MD | US | MD | US | MD |
| Congenital rubella syndrome | 9 | 0 | 7 | 0 | 9 | | 5 | |
| Diphtheria | 3 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Haemophilus influenzae | 1,412 | 81 | 1,264 | 49 | 592 | 24 | 399 | 10 |
| Hepatitis B | 16,126 | 395 | 12,396 | 273 | 215 | 3 | 142 | 3 |
| Measles | 2,231 | 17 | 281 | 4 | 1,116 | 5 | 104 | 2 |
| Mumps | 2,485 | 93 | 1,640 | 84 | 364 | 13 | 275 | 11 |
| Pertussis | 3,935 | 47 | 6,335 | 171 | 2,261 | 29 | 3,753 | 85 |
| Poliomyelitis, paralytic | - | | - | | - | | - | |
| Rubella | 157 | 5 | 195 | 2 | 24 | 0 | 36 | 0 |
| Tetanus | 44 | 0 | 43 | 0 | 0 | 0 | 1 | 0 |

*Data for 1992 are final and for 1993, provisional

On the following pages are case definitions for public health surveillance established by the Council of State and Territorial Epidemiologists (MMWR 1990; 39: 1-43). All of the vaccine preventable diseases listed are reportable to the local health department in Maryland.

Haemophilus influenzae (Invasive Disease)

Clinical description

Invasive disease due to *Haemophilus influenzae* may produce any of several clinical syndromes, including meningitis, bacteremia, epiglottitis, or pneumonia

Laboratory criteria for diagnosis

- Isolation of *H. influenzae* from a normally sterile site

Case classification

Probable: a clinical compatible illness with detection of *H. influenzae* type b antigen in cerebrospinal fluid

Confirmed: a clinically compatible illness that is culture confirmed

Comment

Antigen test results in urine or serum are unreliable for diagnosis of *H. influenzae* disease.

Hepatitis B, Viral

Clinical case definition

An illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels

Laboratory criteria for diagnosis

IgM anti-HBc-positive (if done) or HBsAg-positive, and IgM anti-HAV-negative (if done)

Case classification

Confirmed: a case that meets the clinical case definition and is laboratory confirmed

Measles

Clinical case definition

An illness characterized by all of the following clinical features:

- a generalized rash lasting ≥ 3 days
- a temperature ≥ 38.3 C (101 F)
- cough, or coryza, or conjunctivitis

Laboratory criteria for diagnosis

- Isolation of measles virus from a clinical specimen, or
- Significant rise in measles antibody level by any standard serologic assay, or
- Positive serologic test for measles IgM antibody

Case classification

Suspect: any rash illness with fever

Probable: meets the clinical case definition, has no or noncontributory serologic or virologic testing, and is not epidemiologically linked to a probable or confirmed case

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed or probable case. A laboratory-confirmed case does not need to meet the clinical case definition.

Comment

Two probable cases that are epidemiologically linked would be considered confirmed, even in the absence of laboratory confirmation.

Mumps

Clinical case definition

An illness with acute onset of unilateral or bilateral tender, self-limited swelling of the parotid or other salivary gland, lasting ≥ 2 days, and without other apparent cause (as reported by a health professional)

Laboratory criteria for diagnosis

- Isolation of mumps virus from clinical specimen, or
- Significant rise in mumps antibody level by any standard serologic assay, or
- Positive serologic test for mumps IgM antibody

Case classification

Probable: meets the clinical case definition, has no or noncontributory serologic or virologic testing, and is not epidemiologically linked to a confirmed or probable case

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed or probable case. A laboratory-confirmed case does not need to meet the clinical case definition.

Comment

Two probable cases that are epidemiologically linked would be considered confirmed, even in the absence of laboratory confirmation.

Pertussis

Clinical case definition

A cough illness lasting at least 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or post-tussive vomiting - and without other apparent cause (as reported by a health professional)

Laboratory criteria for diagnosis

- Isolation of *Bordetella pertussis* from clinical specimen

Case classification

Probable: meets the clinical case definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory-confirmed case

Confirmed: a clinically compatible case that is laboratory confirmed or epidemiologically linked to a laboratory-confirmed case

Comment

The clinical case definition above is appropriate for endemic or sporadic cases. In outbreak settings, a case may be defined as a cough illness lasting at least 2 weeks (as reported by a health professional). Because direct fluorescent antibody testing of nasopharyngeal secretions has been shown in some studies to have low sensitivity and variable specificity, it should not be relied on as a criterion for laboratory confirmation.

Rubella

Clinical case definition

An illness with all of the following characteristics:

- Acute onset of generalized maculopapular rash
- Temperature 37.2 (99 F), if measured
- Arthralgia/arthritis, or lymphadenopathy, or conjunctivitis

Cases meeting the measles case definition are excluded. Also excluded are cases with serology compatible with recent measles virus infection.

Laboratory criteria for diagnosis

- Isolation of rubella virus, or
- Significant rise in rubella antibody level by any standard serologic assay, or
- Positive serologic test for rubella IgM antibody

Case classification

Suspect: any generalized rash illness of acute onset

Probable: a case that meets the clinical case definition, has no or noncontributory serologic or virologic testing, and is not epidemiologically linked to a laboratory-confirmed case

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a laboratory-confirmed case

Rubella Syndrome, Congenital

Clinical description

An illness of newborns resulting from rubella infection in utero and characterized by symptoms from the following categories:

A. Cataracts/congenital glaucoma, congenital heart disease, loss of hearing, pigmentary retinopathy

Associated symptoms may be:

B. Purpura, splenomegaly, jaundice, microcephaly, mental retardation, meningocencephalitis, radiolucent- borne disease

Clinical case definition

Presence of any defects or laboratory data consistent with congenital rubella infection (as reported by a health professional)

Laboratory criteria for diagnosis

- Isolation of rubella virus, or
- Demonstration of rubella-specific IgM antibody, or
- An infant's rubella antibody level that persists above and beyond that expected from passive transfer of maternal antibody (i.e., rubella HI titer that does not drop at the expected rate of a twofold dilution per month)

Case classification

Possible: a case with some compatible clinical findings but not meeting the criteria for a compatible case

Compatible: a case that is not laboratory confirmed and that has any two complications listed in (A) above, or one complication from (A) and one from (B)

Confirmed: a clinically compatible case that is laboratory confirmed

Comment

In compatible cases, either or both of the eye-related findings (cataracts and congenital glaucoma) count as a single complication.

Diphtheria

Clinical case definition

An upper respiratory tract illness characterized by sore throat, low-grade fever, and an adherent membrane of the tonsil(s), pharynx, and/or nose without other apparent cause (as reported by a health professional)

Laboratory criteria for diagnosis

- Isolation of *Corynebacterium diphtheriae* from a clinical specimen

Case classification

Probable: meets the clinical case definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory-confirmed case

Confirmed: meet the clinical case definition and is either laboratory confirmed or epidemiologically linked to a laboratory-confirmed case

Comment

Cutaneous diphtheria should not be reported.

Poliomyelitis, Paralytic

Clinical case definition

Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss (as reported by a physician)

Case classification

Probable: a case that meets the clinical case definition

Confirmed: a case that meets the clinical case definition and in which the patient has a neurologic deficit 60 days after onset of initial symptoms, has died, or has unknown follow-up status

Comment

All suspected cases of paralytic poliomyelitis are reviewed by a panel of expert consultant before final

The National Vaccine Advisory Committee's recommended Standards for Pediatric Immunization Practices are listed below. These national Standards are recommended for use by all health professionals providing care in public or private health care settings who are administering vaccine or managing immunization services for children. Adherence to Standards 7, 8, and 12 would help raise immunization levels in Maryland.

If you are interested in analyzing immunization levels in your clinic, (Standard 14) please contact Diane Dwyer, M.D., at 410-225-6671.

Standards for Pediatric Immunization Practices

- | | | |
|-------------|--|--|
| Standard 1. | Immunization services are readily available | vaccine doses for which a child is eligible at the time of each visit |
| Standard 2. | There are no barriers or unnecessary prerequisites to the receipt of vaccines | Standard 9. Providers use accurate and complete recording procedures |
| Standard 3. | Immunization services are available free or for a minimal fee | Standard 10. Providers co-schedule immunization appointments in conjunction with appointments for other child health services |
| Standard 4. | Providers utilize all clinical encounters to screen and, when indicated, immunize children | Standard 11. Providers report adverse events following immunization promptly, accurately and completely |
| Standard 5. | Providers educate parents and guardians about immunization in general terms | Standard 12. Providers operate a tracking system |
| Standard 6. | Providers question parents or guardians about contraindications and, before immunizing a child, inform them in specific terms about the risks and benefits of the immunizations their child is to receive | Standard 13. Providers adhere to appropriate procedures for vaccine management |
| Standard 7. | Providers follow only true contraindications | Standard 14. Providers conduct semi-annual audits to assess immunization coverage levels and to review immunization records in the patient populations they serve |
| Standard 8. | Providers administer simultaneously all | |

classification occurs. Only confirmed cases are included in Table 1 in the Morbidity Mortality Weekly Report (MMWR). Suspected cases ARE enumerated in a footnote to the MMWR table.

Tetanus

Clinical case definition

Acute onset of hypertonia and/or painful muscular contractions (usually of the muscles of the jaw and neck) and generalized muscle spasms without other apparent medical cause (as reported by a health professional)

Case classification

Confirmed: a case that meets the clinical case definition

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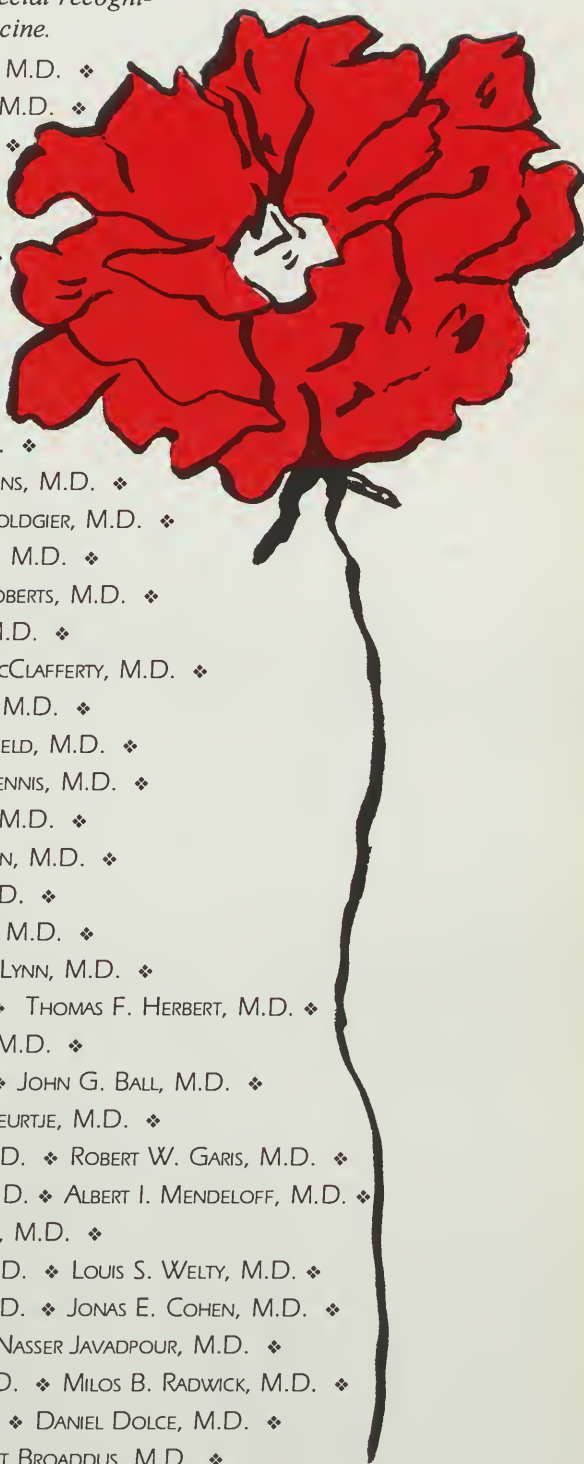
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Auxiliary

Doctors' Day, March 30, 1994

As we commemorate Doctors' Day 1994, members of the Auxiliary to the Medical and Chirurgical Faculty of Maryland and its component auxiliaries offer special recognition to the following physicians for their dedication and service to medicine.

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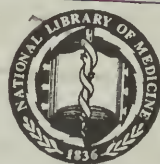
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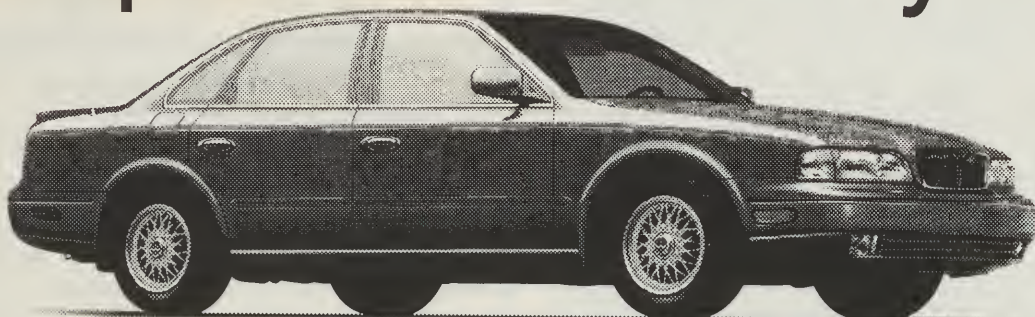
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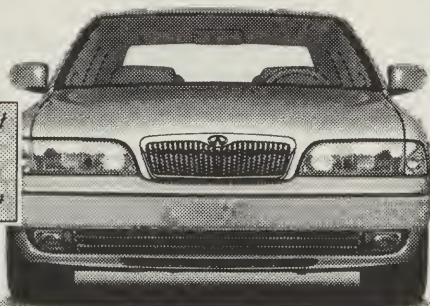
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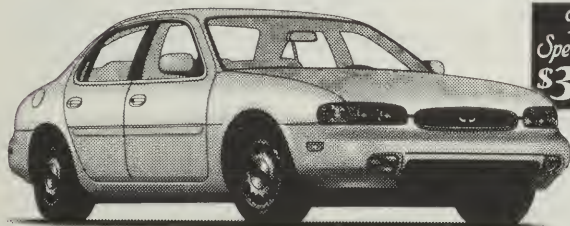


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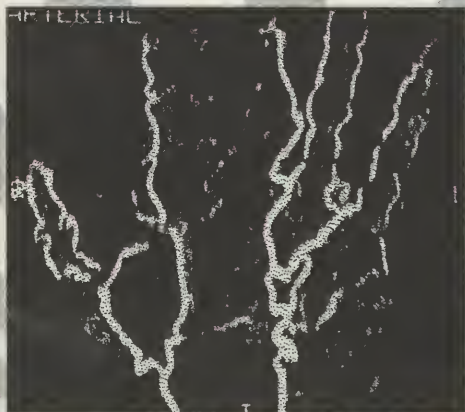
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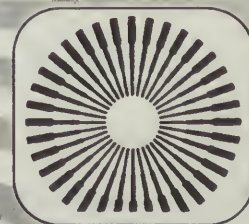
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Cover: The depth of the artist's anguish is reflected in her art. A young adolescent faced with a family crisis, and in therapy as a result of her sexual victimization, she debates the choice between life and death. She chose to live.

For more information about the use of art in therapy, see page 361.


Cover design: Virginia Carter

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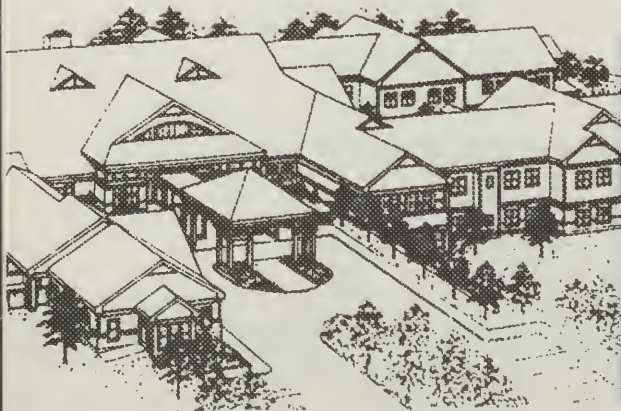
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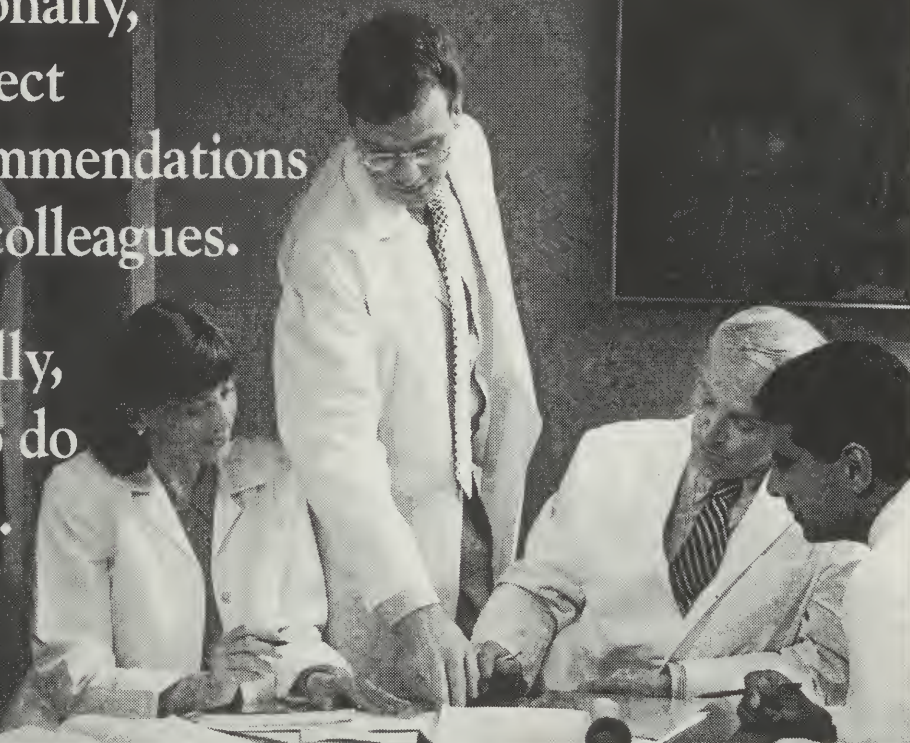
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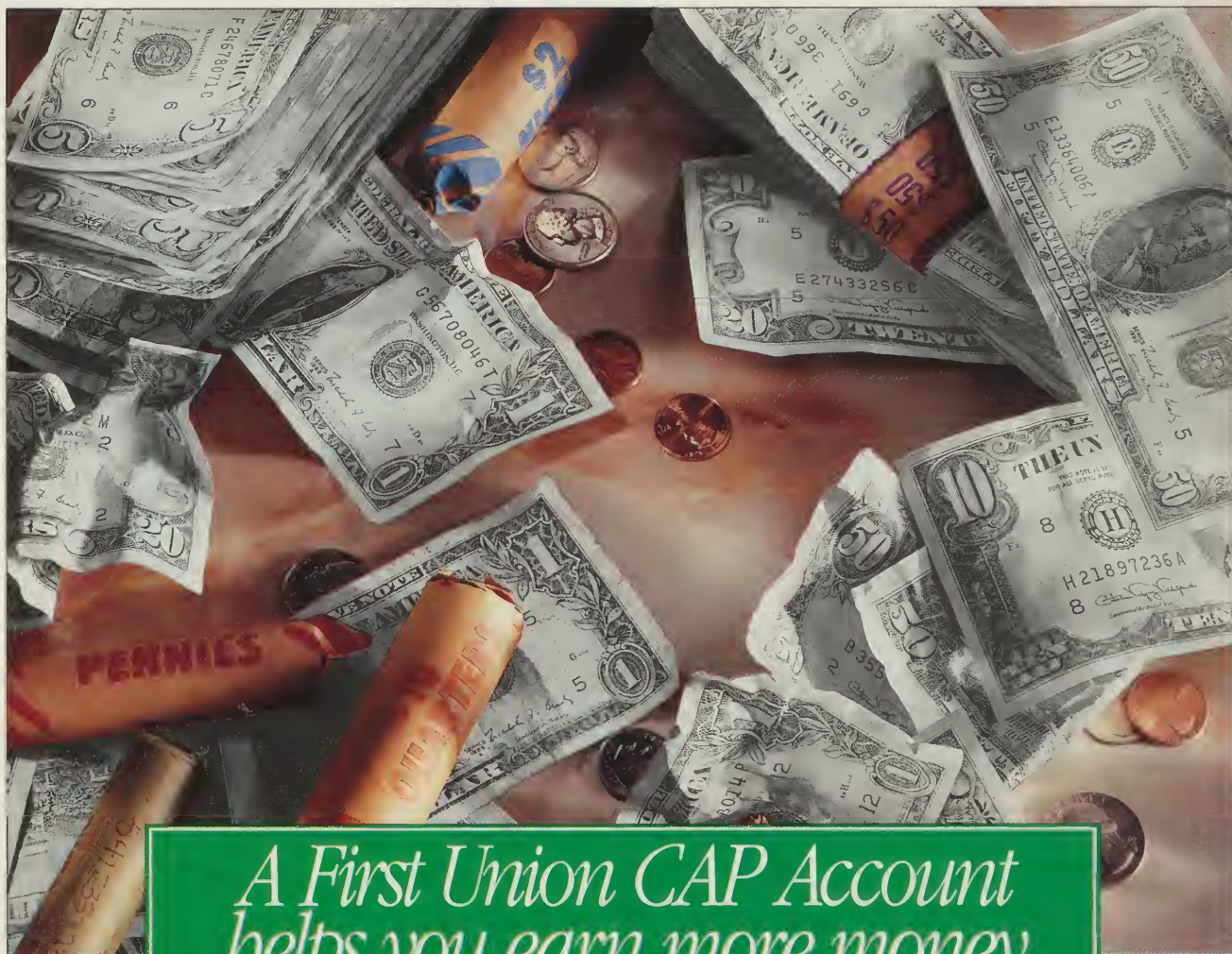
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April 1994

April 1994 MMJ
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This issue of the *Maryland Medical Journal* is dedicated to the subject of child abuse. For more information, please see the President's Letter immediately following this issue of the *Chief Executive Officer's Newsletter*.

Nominations for 1994-1995 Med Chi Officers

The following is the listing of the slate of officers selected by the Med Chi nominating committee for the year 1994-1995. Additional nominations for officers will be accepted during the House of Delegates meeting on Friday, May 13, 1994, at 2:30 pm. The election will be held on Saturday, May 14, 1994, during the House of Delegates meeting which begins at 2:00 pm. Both meetings will be held at the Ramada Inn and Convention Center, Hagerstown, Maryland. (For directions to this meeting, see the preliminary program in the March 1994 issue of the *Maryland Medical Journal*.)

(Those elected will assume office at the conclusion of the 1994 annual meeting, unless otherwise indicated.)

For presentation at the House of Delegates Friday, May 13, 1994:

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April 6, 1994

New Breast Implant Booklets

The Maryland Department of Health and Mental Hygiene (DHMH) is distributing new breast implant booklets. These booklets replace all materials developed prior to October 1993, and include the most current and complete information the Food and Drug Administration provides to consumers about breast implants. Maryland law (Article 20-114) requires physicians to give patients who are considering breast implant surgery information about the advantages, disadvantages, and risks associated with a breast implantation at least five days prior to the surgery. Distributing these new booklets to patients fulfills a physician's obligation under the law. To obtain copies of the new booklets, indicate the number of breast augmentation, breast reconstruction, and signature forms needed for your practice, in writing to: DHMH, Local and Family Health Administration, Division of Cancer Control, Room 304, 201 West Preston Street, Baltimore, Maryland 21201-2399.

Doctor's Role in Early HIV (from AMNews 2/7/94)

About 1 million U.S. residents — 1 in 250 — are HIV-infected. AIDS specialists can't treat them all. Primary care physicians must learn to manage early infection, including:

- ▶ Disclosure of HIV status; risk-prevention counseling;
- ▶ Monitoring of CD4 lymphocyte counts;
- ▶ Prevention of *Pneumocystis carinii* pneumonia and tuberculosis;
- ▶ Initiation on antiretroviral therapy;
- ▶ Syphilis treatment;
- ▶ Eye and oral care;
- ▶ Pap smears;
- ▶ Care of pregnant women;
- ▶ Diagnosis of infants and children; and
- ▶ Development of comprehensive case-management systems that cover social services and health care and involve patients in treatment decisions.

Health Reform Opinion Poll

A March Wall Street Journal/NBC poll found the American public had a greater confidence in the AMA's health reform proposal (41%) than in the Clinton plan (39%). The poll conducted of 1,500 Americans by Peter Hart and Associates expressed preference in the AMA's reform ideas over those of Clinton, insurance companies, hospital groups, the U.S. Chamber of Commerce, labor unions, or the National Association of Manufacturers. The poll also found people thought it was very important to get information on reform from doctors (54%) in comparison to the newspaper (46%); their employer (37%); President Clinton (46%); or their congressman (41%).

Source: AMA Electronic Bulletin Board, 4/23/94

Med Chi Study Group for Alternative Medicine

"Psychoneuroimmunology (Biopsychology): the Basis of the Mind-Body Interface" is the title of the program that will be presented by Leonard A. Wisneski, M.D., clinical professor of medicine at George Washington University Medical School and director of medical education at Holy Cross Hospital, Silver Spring, at the third meeting of the Med Chi Study Group for Alternative Medicine. The meeting will be held on Wednesday, May 4, 1994, at 7:30 p.m. in the Med Chi Faculty Building. Med Chi members, nonmember physicians, and other health care professionals are invited to attend. Please call Steve Jones at Med Chi at 410-539-0872 or 1-800-492-1056, ext. 343, or Hiroshi Nakazawa, M.D., at 410-644-1502, if you wish to attend or would like to receive additional information regarding the study group.

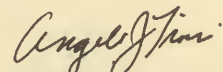
*More Codes Added to
Those Payable for
Assistant at Surgery*

Medicare reinstated payment for more than 700 surgical procedures previously included under the assistant surgery ban. The following additional codes have now been added to that group and now payable for assistant at surgery:

| | | | | |
|-------|-------|-------|-------|-------|
| 24863 | 29822 | 33820 | 63078 | 65285 |
| 25350 | 31588 | 35121 | 63307 | 66682 |
| 25620 | 33411 | 50065 | 65155 | 67320 |

Because the 1993 fee schedule database was incorrect, payment for assistant at surgery for these codes is retroactive to January 1, 1993. If you have had claims denied for these services, resubmit to your Medicare Carrier for adjustment.

Source: EVPgram, Medical Society of the State of New York, 3/25/94



Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

Dear Colleague:

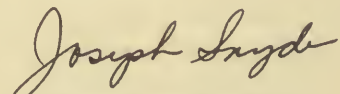
April is National Child Abuse Prevention month, therefore Med Chi has dedicated this month's issue of the *Maryland Medical Journal* to the subject of child abuse.

The inspiration for this issue was conceived during a meeting of the task force for the Maryland Physicians' Campaign Against Family Violence. The task force has begun its endeavors with an educational format targeting domestic violence; its next effort will focus on child abuse.

Please take the time to read this propitious issue. The guest editorial by Congresswoman Constance Morella and the articles were selected to educate you and familiarize you with the devastating effects of child abuse and family violence. I am sure you also will be moved by the poems and the children's art, done by courageous people who are to be commended for allowing us to reproduce their work.

As the Maryland Physicians Campaign Against Family Violence advances, I hope you will join me in Med Chi's efforts to engage the medical community in a very active role against family violence. Let's join together to "unlock the silence" that surrounds this issue.

Sincerely,

A handwritten signature in cursive script that reads "Joseph Snyder".

Joseph Snyder, M.D.

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| 45 | 1745 | 2105 | 2645 |
| 50 | 2555 | 3255 | 4075 |
| 55 | 3945 | 5155 | 6325 |
| 60 | 6425 | 8285 | 9965 |

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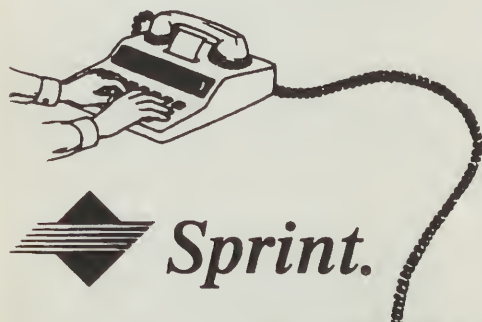


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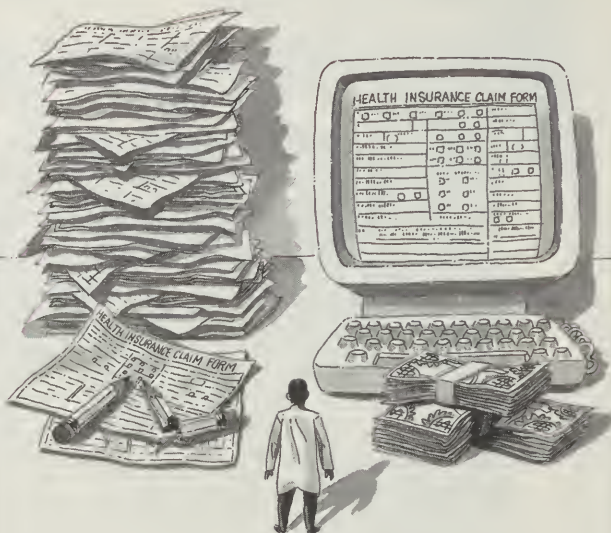
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- **Once-a-day dosing**

- **Low incidence of adverse effects**

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TABLETS

* In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes ($P=.04$). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo ($P=.03$).

Please see following page for brief summary of Prescribing Information.

CLARITIN®
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TABLETS
Long-Acting Antihistamine

BRIEF SUMMARY
(For full Prescribing Information, see package insert.)

INDICATIONS AND USAGE
CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{0-12h}/AUC_{0-12h} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS

Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN
PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS
PERCENT OF PATIENTS REPORTING

| LO RATADINE 10 mg QD n = 1926 | PLACEBO n = 2545 | CLEMASTINE 1 mg BID n = 536 | TERFENADINE 60 mg BID n = 884 |
|-------------------------------------|---------------------|-----------------------------------|-------------------------------------|
| Headache | 12 | 8 | 8 |
| Somnolence | 8 | 6 | 9 |
| Fatigue | 4 | 3 | 2 |
| Dry Mouth | 3 | 2 | 3 |

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing
Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema

Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.

Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System Arthralgia, myalgia.

Psychiatric Anxiety, depression, agitation, insomnia, paranoia, amnesia, impaired concentration, confusion, decreased libido, nervousness.

Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.

Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.

Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.

Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema; abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis; alopecia; seizures; breast enlargement; erythema multiforme; and anaphylaxis.

OVERDOSAGE

Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdose, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdose would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis; it is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD₅₀ values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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17790803-JBS

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Reference

1. Bedard P-M, Del Carpio J, Drouin MA, et al. Onset of action of loratadine and placebo and other efficacy variables in patients with seasonal allergic rhinitis.
Clin Ther. 1992;14:268-275.

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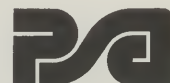
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Violence in the home: no more excuses

The problem

For many women and children, real terror is not walking home alone down dark city streets. Real terror is staying home with their "loved ones."

Many women and children in this country, regardless of their race, neighborhood, education, or income, face violence in their everyday life. The statistics are shocking.

- Every five minutes a woman is raped.
- Every fifteen seconds a woman is beaten by her spouse or her intimate partner.
- Every year 3.3 million children watch their fathers beat their mothers.

Children are domestic violence's victims and its silent witnesses. Children in violent homes are physically abused or seriously neglected at a rate 1500% higher than the general population. Often, male children who witness domestic violence learn to cope with life through aggressive behavior that leads to more violence in our society. Girls tend to cope with domestic violence through passive indifference that can contribute to teenage pregnancy, drug and alcohol abuse, and suicide.

Lenore E. Walker, Ed.D., a clinical psychologist who has written extensively on domestic violence, maintains that "spouse abuse is child abuse. Whether or not [children] are physically abused by either parent is less important than the psychological scars they bear from watching their fathers beat their mothers. They learn to become part of a dishonest conspiracy of silence."

Lying to avoid further unpleasant confrontations, often escaping into a world of make-believe, feeling guilty because they cannot protect their mothers, these children grow up in an environment where violent behavior is the acceptable approach to problem solving.

Domestic violence can harm children even before birth. Fifteen to twenty-five percent of all pregnant women are struck during pregnancy. Battered women are twice as likely to have miscarriages than women who are not battered. Battered women are more likely to have a stillborn child and twice as likely to bear a low birthweight baby.

In addition to its effects on children, domestic violence has profound effects on women's health. Battering causes more injuries to women than car accidents and muggings combined. According to estimates, one-third of all women who come to emergency rooms for treatment are battering victims.

Every year, domestic violence generates 98,800 hospitalizations, 28,700 emergency room visits, and 39,000 physician visits.

A study conducted by the San Francisco-based Family Violence Prevention Fund found that in California hospitals, only 5% of the victims of domestic violence who came to emergency rooms for treatment were identified by emergency personnel as abuse victims. Less than 25% of those hospitals had training programs about domestic violence. Some manifestations of abuse are easy to see—broken bones, blackened eyes, or smashed jaws. Other consequences of abuse—anxiety, depression, eating disorders, clinical dependency, chronic headaches, and suicide—often are not associated with their true cause.

Health care professionals usually are not trained how to interview a possible abuse victim. They do not know what questions to ask, how to ask them, or what to do after they get the answers. Clinical protocols must be developed to help physicians, nurses, emergency room personnel, and ambulatory care providers recognize the symptoms of battering, and how to treat battered women and children. Medical data about these victims can be used to identify effective methods of treatment and prevention.

As a society, for too long we have regarded domestic violence as a “lesser” crime, one that has not been rigorously prosecuted or punished. Until fairly recently, domestic violence was dismissed as a private matter between partners. Family and friends looked the other way, doctors and nurses overlooked the symptoms, and police and judges simply “failed to protect.”

Domestic violence legislation

Several federal bills are designed to help the health and legal communities confront domestic violence. The Women’s Violence-Related Injury Reduction Act (H.R. 1829) was added to the reauthorization bill for the Injury Control Program at the Centers for Disease Control (CDC). The legislation, which passed the House and Senate and was signed by the President in December 1993, will provide

- for hospital-based demonstration projects to identify and to treat victims of domestic violence and sexual assault;
- for public education programs about the health consequences of domestic violence;
- for epidemiological research by the CDC to determine the incidence, types, and effects of domestic violence nationwide.

Another piece of legislation, the Domestic Violence Identification and Referral Act (H.R. 3207), will advance medical education about domestic violence. This bill will require medical schools and other health professional schools to include training on domestic violence in their curricula, or risk losing a portion of their federal funding.

Guest Editorial

According to the NOW Legal Defense and Education Fund, "Women and girls are targeted for many types of violence because of their sex. When half of the members of our society are at greater risk of terror, brutality, serious injury, and even death just because they are female, that is a form of discrimination."

The Violence Against Women Act (H.R. 1133 and S. 11) addresses this type of discrimination. The bill passed the House and Senate in November 1993, and this spring, a House-Senate conference committee will reconcile differences between the two versions of the bill before it goes to the President for his signature. The bill's provisions include:

- requiring all states to enforce orders of protection, regardless of the order's state of origin, and encouraging mandatory arrest policies in domestic violence cases;
- funding for more effective law enforcement and prosecution strategies for rape and rape prevention programs in our schools;
- funding for nationwide, toll-free, multilingual hotline assistance for battered women;
- allowing battered immigrant women married to U.S. citizens or permanent residents to self-petition for legal resident status for themselves and their children;
- training for state and federal court judges about rape, domestic violence, and other kinds of sexual assault;
- funding for campus rape prevention programs; and
- urging all states to allow battered women to present evidence of past abuse in criminal trials.

The Senate version also

- declares that crimes motivated by gender are bias crimes and civil rights violations that will be treated in the same manner as crimes committed because of racial, religious, or ethnic hatred.
- provides funding for emergency shelters for battered women and their children, and for increased safety measures for public transportation, parks, and streets.

In addition to this legislation, the Judicial Training Act (H.R. 1253), which passed the Congress in 1992, awarded \$160,000 to the Family Violence Prevention Fund to develop a national training program for judges to assist them in arbitrating child custody cases where "abuse of one parent by the other" is alleged.

We have made progress in educating the public about violence against women, in establishing counseling programs and shelters for abused women and their children, and in writing laws that treat domestic violence as a serious crime with serious consequences. But we have so much more to do.

Guest Editorial

We must continue to speak out on these and other family health issues on Capitol Hill and in our local communities. We must continue to work for better funding for law enforcement and judicial organizations that offer training for police, judges, and court personnel about domestic violence. We must also work to increase funding for shelters, and for educational programs for children about violence and its consequences. As Congress debates health care reform, we must work diligently to ensure that treatment for women and children who have been victimized by family violence and sexual abuse is included in any health care package that is approved.

The role of health care professionals

Physicians, nurses, and other health care professionals are on the frontline in the battle against family violence. Many of you will see the victims of domestic violence—women and children—long before a police officer, an attorney, or even a close friend. Women frequently visit hospital emergency rooms or their doctors long before they finally seek legal protection.

Medical providers should consider the following when examining a patient:

- does the stated origin of injury match the type of injury you are seeing? Could the bruises or cuts **really** be the result of falling down stairs?
- how does the patient's family solve disputes?
- does the patient exhibit symptoms of drug or alcohol abuse or depression?
- do you carefully document what you see? Medical records are often the court's "eyes and ears," that allow the judge to "see" what happened to a woman.

If we are to rid our society of domestic violence and its terrible consequences, we must work together—physicians and other health care professionals, attorneys, social workers, police, judges, and lawmakers. And we must always remember that violence against another human being is **always** criminal behavior. That is the bottom line.

There is just no excuse for family violence.

CONSTANCE A. MORELLA

Washington, D.C.

Congresswoman Morella is a member of the House of Representatives from Maryland's eighth district. ■

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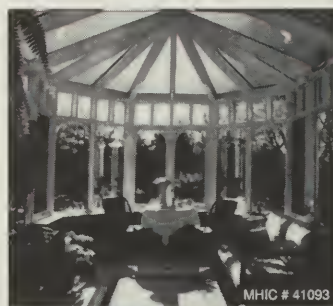
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Speak Out

Health care cost and its containment: the dilemma of conflicting law, ethics and economics

Little more than a decade ago, the main goal of the health care system in the United States was to use advances in medical science and technology to provide high quality health care to all socioeconomic groups. Recently, however, advances in medical science and the widespread availability of sophisticated medical care have led to spiraling health care costs that are increasing without control or containment.

In 1970, health care, education, and defense each consumed about 6% of the gross national product (GNP). At that time, the nation spent \$236 billion on defense, \$218 billion on education and \$215 billion on health care. By 1992, defense and education spending dropped slightly; adjusted for inflation, these areas used approximately 5% of the GNP. Health care costs, however, reached 14% of GNP, totaling an astounding \$820 billion. In other industrial nations with universal health systems, health care costs have stabilized to between 8-10% of the G.N.P.¹

Many factors contribute to this country's spiraling health care costs. These factors include

advanced technology. Incredible advances have taken place in all fields of medical sciences. For example,

- diagnostic radiology and imaging, CT scan, MRI, MRA, and three dimensional reconstruction;
- interventional radiology, e.g., coronary artery balloon angioplasty, embolization of arteriovenous malformation (AVM) and aneurysms in brain and spinal cord, and coronary atherectomy;
- critical care and anesthesiology—today we can virtually bring patients back to life with full control of their vital functions;
- biochemistry and biomedical engineering—advances in diagnostic chemistry and pharmacology have led to the development of new, often expensive, therapeutic agents; and
- genetic engineering—revolutionary development in this field has given us safer vaccines.

administrative costs. Estimates suggest that forty cents out of each health care dollar goes toward administrative costs.

practice of defensive medicine. It is estimated that fifteen cents out of each health care dollar is spent on defensive medicine. Defensive medicine costs

Speak Out

include increased diagnostic testing for patients and higher malpractice premiums for physicians.

Although statistical figures aren't available, it is widely believed that physicians must order many more diagnostic tests than are necessary to establish a diagnosis. Physicians order such tests to conform to *customary practice*, a crucial issue in medical malpractice liability cases. The American Medical Association (AMA) estimates that in 1989 alone, physician costs for tests over and above what was necessary amounted to \$15.1 billion.²

Nationwide, the cost of physician medical liability insurance has risen from \$1.7 billion in 1982 to \$5.6 billion in 1989. This amount does not include insurance premiums paid by hospitals, other allied health care professionals, or manufacturers of medical goods. The cost of all insurance is passed on to consumers through higher fees.

Despite widespread malpractice litigation, the legal system often fails the injured party by usurping the largest percentage of any award. Typically, the judicial process takes 57% of the liability dollars awarded in such a case. Most malpractice lawyers charge 50% of the award as their contingency fee. After paying judicial costs—discovery costs, deposition costs, court costs, expert witness costs and filing costs—and the lawyers' fees, the plaintiff is left with a very small fraction of the total award to compensate for his or her injury.

Cost containment and medical law

In 1983, Medicare and Medicaid, the principal providers of health care insurance to the elderly and poor, responded to spiraling health care costs by replacing the retrospective cost reimbursement system with a prospective payment system. Under the new system, the Health Care Financing Administration (HCFA) would pay hospitals based on diagnostic related groups (DRGs). Hospitals then began to pressure physicians to order fewer diagnostic tests and procedures, and to discharge patients sooner.³ Many physicians feel that these new pressures seriously compromise the quality of care because medical decisions are being made based upon cost containment measures.^{3,4,5} Additionally, physicians are concerned because they, rather than the hospital or third party payor, face potential malpractice suits from patients who suffer damage or injury because of early discharge from the hospital, or because certain medical procedures were not done. Physicians who provide health care to the elderly and poor may have a higher risk for these type of malpractice suits because medical resources are not distributed uniformly, and are less likely to be available to the poor and elderly. The uneven distribution of medical resources, known as stratified scarcity,⁶ is magnified by cost containment measures such as those implemented by Medicaid and Medicare.

Although implementation of cost containment is increasing throughout the health care system, medical malpractice laws remain unchanged. Since medical

Speak Out

malpractice litigation is a factor that affects the distribution of medical resources, cost control measures must be reconciled with medical malpractice laws.

The following modifications to the legal system would help align cost containment strategies with laws regulating the health care industry.

Cost as a defense. As previously stated, malpractice suits could be brought against a physician who uses cost containment practices. These potential lawsuits could deter physicians from providing medical care to those most affected by the cost containment—the elderly and the poor. Additionally, physicians subject to unavoidable economic constraints face difficult moral and potentially unfair ethical decisions.⁶ The unfairness of such liability can be mitigated by allowing physicians an explicit cost based defense.⁷

A cost based defense would require a special design and specifics.⁸ Under such an approach, physicians would still be obligated to provide each patient the same standard of care, regardless of economic resources. However, during a malpractice suit, physicians could contend that breaches in standards of care were caused by an appropriate response to cost containment incentives rather than negligence. Physicians could use the third party payor's overall economic condition or the hospital's uncompensated care burden as evidence for this defense. Physicians also could show that economic constraint policies dictated a particular action, or that economic pressures were applied by a third party payor. Lastly, physicians must show that alternatives to the cost conscious decision were pursued to a reasonable degree.⁹

A defense for cost conscious decision making arising from adherence to cost containment strategies has the advantage of easy implementation within the existing structure of tort law.¹⁰ However, it is generally believed that a cost based defense dilutes the deterrent effect of medical malpractice law and implicitly sanctions the current distribution of medical resources.⁹

Shared tort liability. Under the prospective payment system, hospitals exercise a great deal of pressure on physicians for cost containment decisions. Physicians, on the other hand, are liable for every diagnostic and therapeutic decision. Hospitals' liability is therefore limited.¹⁰

Under the shared tort liability approach, liability is shared by the physician and hospital, and could be rebutted by the hospital.¹¹ This approach has several advantages, including (1) hospitals will not reduce their services indiscriminately; (2) the practice of defensive medicine and its associated costs will decrease because of the reduced risk of malpractice suits for physicians; (3) shared liability should provide incentives for both physicians and hospitals to find cost containment measures that are medically and economically sound and feasible.⁹

On the other hand, shared physician/hospital liability can generate increased court costs from litigating the rebuttable presumption issue. The appointment of liability between physician and hospitals is a causation issue which can also increase litigation costs.¹⁰ Lastly, sharing liability with an insolvent hospital may

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not be of much help for physicians practicing at public facilities whose financial solvency is precarious.⁷

Shared liability between physician and payors. Health insurance agencies and government are unwilling to be held responsible for medical malpractice suits which arise as a result of cost containment practices. The government and third party payors should be equally responsible for inappropriate medical decisions and consequent injury from the deprivation of appropriate and optimum care due to cost containment. Injured patients should be compensated from all the parties responsible for such a deprivation, including the third party payor and the government.¹⁰

Shared liability between physicians and payors has the potential to reconcile the conflicting legal and economic incentives in health care delivery.¹² This shared liability does not relieve the physician from his or her duty to function as patient advocate.¹² The court in California recently stated during a shared liability case, "while we recognize realistically that cost containment has become a permanent feature of health care systems, it is essential that cost limitation programs not be permitted to corrupt medical judgement."¹²

Shared liability should also apply to hospitals owned by the government and charitable organizations.

Contracts between patients and insurers. Currently, most patients choose their health insurance from a variety of plans with various financial arrangements. Since patients choose their health care plans, they are more familiar with the plan's risks and limitations than the legal system. Therefore, patients should also be allowed to choose the type of legal protection they want with respect to their health insurance plans.

A contractual agreement could occur between individual physicians and patients or between groups of physicians and third party payors like health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and groups of patients. This contract would modify or alter the legal responsibility of health care providers and legal rights of the patient.⁸ The patient will have the right to choose legal options including (1) waiving the right to a jury trial by agreeing to binding arbitration; (2) limiting malpractice recovery rights such as economic damages; (3) bargaining for a lesser standard of care reflective of the role of cost conscious decision making.¹⁰

The legal profession may not be willing to accept private contracts that define patients' rights. Courts view physicians and hospitals like innkeepers and common carriers that patients turn to out of necessity.¹³ Some reasons that the legal profession cites for prohibiting exculpatory agreements between patients and physicians are (1) health care is a necessity of life; in contracting for its provision, the physician's superior bargaining power should not prevail;¹⁴ (2) exculpatory clauses have no place in the practice of the learned profession;¹⁵ (3) private agreements between physicians and patients should not reduce a physician's statutory or ethical duties;¹⁶ and (4) the disparity of bargaining power

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between physicians and patients is so extreme that the results of bargaining should be ignored.¹⁴

However, if the agreement is not imposed on patients under circumstances limiting their opportunities to bargain for a different arrangement or to choose an alternative provider, the courts will be less concerned about protecting the patient's rights by judicial intervention.¹⁷

Even though the private contract approach is feasible, the fact remains that many patients often lack the requisite freedom of choice needed to assure the courts that the final contract is negotiated by two parties with equal bargaining power.¹⁰ However, limited choice need not be legally fatal. The limitations of the contract approach can serve as a paradigm for ultimately resolving the conflict between cost containment and medical liability.¹⁰

Cost containment could be legitimized, and the conflict with medical liability resolved, if public health care funding resources, whether enacted by the Congress or state legislators, explicitly combine the delivery of health care with the acceptance of a standard of care subject to cost conscious medical decision making. If enacted, the courts will be faced with deciding within the issue of contractual bargaining power, whether society has the right to legislate a health care cost containment program which ensures its own effectiveness by allowing physicians and patients to contract for a less cost conscious standard of care than currently exists.¹⁰

Conclusion

This nation is in the process of redefining the goals of our health care system. Access to health care and the quality of that care now seem less desirable than containing health care costs. During this change, society has developed conflicting expectations of our health care system. Limited government funding is colliding with society's historic support for a broad range of public financed health benefits.¹⁰ Society now expects physicians to provide cost conscious care, and to ignore the potential legal ramifications of doing so. Laws regulating health care require physicians to provide standard and reasonable care, regardless of resources; however, resource constraints may prevent physicians from delivering customary levels of care under some circumstances. If the law fails to address the fact that cost containment strategies can adversely affect standards of care, physicians may be held liable for using cost containment methods that limit a patient's care. On the other hand, if the law allows physicians to use cost containment as a defense in malpractice cases, patients may be denied fair compensation in cases where cost containment adversely affected the quality of patient care.

The legal system should be cognizant of non-legal economic pressures on physicians' decision making.¹⁰ To develop a legal system which addresses the influence cost containment measures have on the standard of care, law-makers should consider (1) retaining the unitary standard of care; (2) strict

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monitoring and rigid control on the use of high technology, including regionalization of high technology and resources; (3) drastic cost cutting measures for administrative costs; (4) allowing cost containment defense in malpractice cases; (5) sharing tort liability with third party payor; (6) eliminating contingency fee law; (7) peer review with minimum standards; (8) private contracting and exculpatory clauses; and (9) resource based reference groups, to help reconcile society's conflicting legal and economic expectations of the health care delivery system.

It is impossible to conceive of any medical care delivery reform without simultaneous reform in the legal system.

CHHABI BHUSHAN, M.B., B.S., L.M.C.C., F.A.C.S.

BONNIE BHUSHAN, M.A.S.

Baltimore, Maryland ■

References

1. Kuttner R. Health care is the mother of all budget busters. *The Baltimore Evening Sun* June 8, 1993; 11A.
2. American Medical Association. AMA/Specialty society medical liability project. Chicago. 1992.
3. Lang HL. A physician looks at DRG's. *West J Med* 1984; 141:248-52.
4. Vance-Bryan D. Medicare's prospective payment system: can quality care survive? *Iowa Law Review* 1984; 69:1417-50.
5. Schwartz. The competitive strategy: will it affect the quality of care? In: Meyer JA (ed). *Market Reforms in Health Care: Current Issues and New Directions, Strategic Decisions*. American Enterprise Institute for Public Policy Research. 1983. pp. 15-20.
6. Morreim EH. Commentary: Stratified scarcity and unfair liability. *Case Western Reserve Law Review* 1985; 1033-57.
7. Morreim EH. Cost containment and the standard of care. *California Law Review* 1987; 75:1719-63.
8. Danzon PM. *Medical Malpractice: Theory, Evidence and Public Policy*. Massachusetts: Harvard University Press. 1985.
9. Furoow BR. Medical malpractice and cost containment: tightening the screws. *Case Western Reserve Law Review* 1985-6; 36:985-1032.
10. Howard JJ. Medical malpractice liability and cost containment: law and economics in conflict. *Food, Drug and Cosmetic Law Journal* 1988; 43:309-334.
11. Notes. Rethinking medical malpractice law in light of medicare cost cutting. *Harvard Law Review* 1985; 98:1004-22.
12. *Wickline v. State of California*. 1983 App. 1175, 1185, 228 California Reporter 661-71 (1986).
13. Marsh. Health care cost containment and the duty to treat. *J Leg Med* 1985; 6:157.
14. *Tunkl v Regents of the University of California*. 60 California Reporter 2d 92-101. 383 Pacific Reporter 2d 441-7. 32 California Reporter 33-9 1963.
15. *Olsen v. Molzen*. 558 South Western Reporter. 2d 429-33 Tennessee 1978.
16. *Emory University v Porubiansky*. 156 Ga. App. 602, 275 South Eastern Reporter. 2d 163, affirmed, 248 Ga., 282 South Eastern Reporter. 2d 903-6, 1981.
17. *Madden v. Kaiser Foundation Hospitals*, 17 Cal. 3d 699, 552 P. 2d 1178, 131 California Reporter 882 1976.



The precarious situation of the medical student

The creation of a national health plan for all Americans is a major issue with the present Washington administration. Health insurance also is a matter of concern to 32 million uninsured individuals. Certainly, all citizens should have the benefit of adequate medical care. However, if health system reform is to succeed, some provisions to lower the cost of a medical education must be made. Otherwise, properly educated personnel will not be available to provide desired care and manage hospitals.

Inquiries at two Baltimore-area medical schools disclosed a tremendous increase in the cost of an education. At the Johns Hopkins University School of Medicine, the average expense, including tuition, for the 1994-95 school year for one student is projected to be \$33,612. At the University of Maryland, expenses for a student who is a Maryland resident are approximately \$20,000 per year. A student who is not a Maryland resident can expect to pay approximately \$30,000. Therefore, the total cost of a four year medical education ranges from \$135,000 at the Johns Hopkins University to \$120,000 at the University of Maryland for an out-of-state student or \$80,000 for a student who is a Maryland resident.

In 1902, the tuition at these schools was slightly more than \$800 for the entire four years. My tuition for 1931-35 was slightly over \$2,000. Admittedly, the cost of just about everything has risen since then, as have wages. However, the cost of a medical education has escalated out of control, and a

reasonable solution to this problem has not been proposed.

Currently, several possible funding alternatives exist for a medical education.

1. Students or their families must be wealthy to pay for a medical education out of their own pockets. This could lead to the unacceptable situation that only the prosperous will attend medical school.

2. Students must borrow money and start their residency years with a heavy debt that they must repay. Unfortunately, many medical school graduates have not repaid their loans.

3. The government could pay for a portion of the education and propose a period of mandatory health service to be fulfilled after graduation. Post-graduate training in non-primary care specialties would be restricted, and graduates would be offered a paid position for two years in an institution affiliated with the national health service. The cost of two years of medical school would be rebated if such a tour were completed successfully.

4. Scholarships, and donations provided by alumni or other interested individuals may help defray a student's expenses, but usually don't cover all educational costs.

No matter what type of plan the government devises to provide health care, skilled professionals will always be needed to deliver this care. Unless a medical education can be made affordable to more people, the country could face a shortage of properly trained physicians.

JOSEPH M. MILLER, M.D.
Timonium, Maryland ■



Regarding "A moment with endocrinology and metabolism"

Maryland Medical Journal

November 1993

I would like to express my disagreement with some of the statements of James H. Mersey, M.D. in the article "A moment with endocrinology and metabolism" in the November 1993 issue of the *MMJ*.

The questioning physician stated that the thyroid scan showed the nodule to take up technetium more than the rest of the gland, but without suppression elsewhere. Frequently, if the scan is performed with ^{131}I or ^{123}I , the nodule would gobble up the iodine and the rest of the gland would have been suppressed.

The above characteristic facilitates the use of ^{131}I for treatment of the nodule, and frequently burns out the nodule. When scanning is performed two or three months later, frequently the remaining tissue takes up iodine normally, and gives a picture of a normal thyroid gland.

Another point I want to make is that there is no indication for an attempted thyroxine suppression in this situation because hyperfunctioning adenomas do not suppress. Even though the author appeared to "beat around the bush" on this question, he did mention that there was a slight chance of suppression.

Lastly, depending on the opinion and philosophy of the attending physician, some endocrinologists prefer to operate on hyperfunctioning adenomas and remove them to possibly prevent the patient from becoming thyrotoxic later. It is extremely rare for such nodules to resolve on their own. Frequently, they do not progress to thyrotoxicosis.

I agree with Dr. Mersey that these adenomas are almost never malignant.

ADOLPH FRIEDMAN, M.D.
Rockville, Maryland ■

LETTERS TO THE EDITOR

The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

Editor
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The author's response

Thank you for your letter in response to the "A moment with endocrinology and metabolism" column on functioning thyroid nodules. This column is meant to be an open forum and your comments are much appreciated.

In response to your comments about scanning with ^{131}I or ^{123}I , I agree that scanning with an iodine isotope should be performed in this situation before considering any therapy. Although you may be correct that iodine scanning would show no uptake outside of the warm nodule, the non-suppressed thyroid stimulating hormone (TSH) suggests

that the rest of the gland would still not be suppressed. I would concur, however, that technetium scans may be misleading.

I also agree that there is little chance of suppressing the nodule with thyroid hormone. Perhaps the words I chose did not correctly convey what I meant.

Concerning the question of surgical removal of non-toxic hot thyroid nodules, I have not recommended such a procedure, nor have I ever heard much enthusiasm for such an operation.

JAMES H. MERSEY, M.D.
Baltimore, Maryland ■

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Teaching physicians about family violence

Martin P. Wasserman, M.D., J.D., and Hiroshi Nakazawa, M.D., P.A.

Dr. Wasserman and Dr. Nakazawa are co-chairs of the
Task Force on Family Violence.

IT IS WITH A SPECIAL SENSE OF PRIDE THAT WE WRITE THE INTRODUCTORY comments to this month's *Maryland Medical Journal* which focuses on child abuse and its prevention. More than two million cases of child abuse and neglect are reported each year, and we know many more cases are not reported. Two thousand deaths each year are attributed to this abuse.

Child abuse and family violence were first considered public health problems by then Surgeon General C. Everett Koop in 1985. In 1992, the American Medical Association (AMA) initiated the Physicians' Campaign Against Family Violence and in September 1993, Med Chi, in conjunction with the Maryland Alliance Against Family Violence (MAAFV), launched the Maryland Physicians' Campaign Against Family Violence with its theme "*Unlock the silence. Trust is the Key.*"

Since the campaign's kickoff in September, Med Chi and MAAFV have formed a task force comprised of experts in three areas—domestic violence or partner abuse, child abuse, and elder abuse. This task force has worked diligently to design the campaign's first set of educational materials on domestic violence. The task force was also instrumental in compiling the articles for this issue of the *MMJ*.

We are especially pleased with the quality and diversity of these articles. The guest editorial by Congresswoman Constance A. Morella describes national legislation which addresses family violence and the role health care professionals can have in preventing further abuse. Representative Morella has been instrumental in providing national legislation in support of women and children, and we thank her for her special leadership.

The first article by Howard Dubowitz, M.D. offers us insight into the most prevalent yet least recognized form of child abuse—neglect. Dr. Dubowitz describes the incidence, etiology, manifestations, and evaluation and management of child neglect cases.

Charles Shubin, M.D. gives us an outstanding set of guidelines for interviewing, examining and treating child victims of sexual abuse in his article "Sexual abuse of children—a primer for physicians."

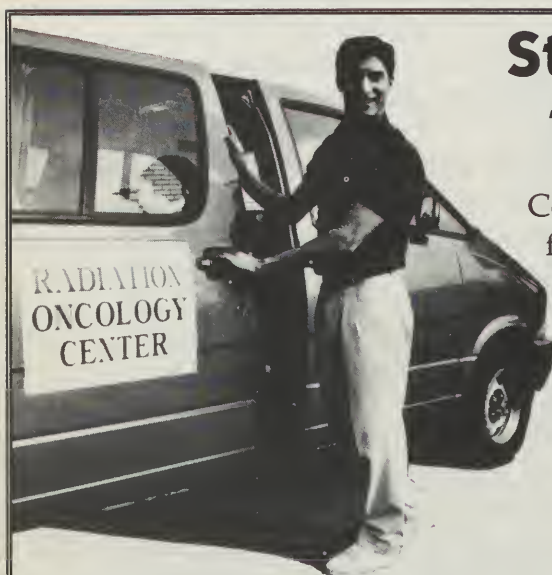
Child abuse is often linked to other types of family violence, and the next three articles describe how the cycle of abuse continues through generations. Jacquelyn Campbell, Ph.D., R.N., F.A.A.N. provides some alarming statistics on the correlation between wife abuse and child abuse. Sallie Rixey, M.D., M.Ed., and Dorothy Thormaehlen, L.C.S.W.—C. and Eena Bass-Feld, M.A., A.T.R., C.P.C. describe the devastating effects growing up in a violent home has on children and adolescents. Ms. Thormaehlen and Ms. Bass-Feld also bring us closer to some family violence victims by sharing these victims' poetry and drawings.

The final article by Julie Drake, J.D. tells us why physicians are so important in legal proceedings for child abuse cases and what we can expect from our legal system when testifying in such a case.

According to AMA research, 80% of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence. The patient's trust is there. Physicians can help break the

cycle of violence by fostering this trust and identifying and treating the victims of family violence. Each of us, regardless of the specific field of medicine that we practice, should become more aware of how we can treat the epidemic of family violence.

We hope that after you read this month's issue of the *MMJ*, you will want to join your colleagues and participate in the Maryland Physicians' Campaign Against Family Violence. We look forward to your joining us at one of our training sessions later this year. ■



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Medical neglect: what can physicians do?

Howard Dubowitz, M.D.

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ABSTRACT: *Neglect is the most prevalent form of child maltreatment. Although the morbidity and mortality associated with it are significant, child neglect has attracted relatively little attention from professionals, the media, and the public. This article focuses on unmet, basic needs of children, particularly with regard to health care. In addition to defining neglect, the article discusses incidence, etiology, various forms of medical neglect, and principles for evaluation and management.*

It is a cliché that child neglect has been neglected.¹ The attention of physicians and others has focused on the more dramatic forms of child maltreatment: physical and sexual abuse. The relative inattention to child neglect is noteworthy because over half the reports of child maltreatment made each year in the United States are for neglect.² In addition, the morbidity³ and mortality⁴ associated with neglect are substantial; approximately half the fatalities due to maltreatment each year result from neglect.⁴

Definition

Neglect occurs when a child's basic needs—food, clothing, a home, education, love, protection, and health care—are not met adequately.⁵ Although the term *adequate* is difficult to specify, in some instances it may be clear, such as a diet that leaves a child hungry and impairs growth. The current child welfare system and state laws confine their concern with child neglect to situations in which the parent(s) or primary caregiver are responsible; their omissions in care are the basis for determining neglect.⁶

Focusing on basic needs appears appropriate because the purpose in diagnosing child neglect is to ensure the child's adequate care and well-being, not to blame parents. Causes of child neglect are less important for identifying child neglect, although they are very important for understanding why neglect occurred and for guiding appropriate interventions.

Table 1. Incidence of child neglect in the United States in 1986²

| Category | Number of children | Rate per 1,000 children |
|---------------------|--------------------|-------------------------|
| Physical neglect | 507,700 | 8.1 |
| Emotional neglect | 203,000 | 3.2 |
| Educational neglect | 285,900 | 4.5 |
| Total neglect | 917,200 | 14.6 |

Actual vs. potential harm. To assess a situation as neglectful, must there be actual harm to a child or is the risk of harm (i.e., endangerment) sufficient? Most states, including Maryland, follow federal guidelines by including potential harm in their definitions.⁶ Given the interest in prevention in pediatrics, it appears important to do so. Many untreated conditions have no immediate consequences, but may have later physical and psychological sequelae. One example is the risk associated with not receiving the childhood immunizations.

Severity. The more severe the actual or potential harm, the more serious is the neglect. Missing a follow-up appointment for a suicidal teenager is more worrisome than missing a check-up after a middle ear infection. The child welfare system generally regards actual harm more seriously than potential harm.

Frequency/chronicity. Omissions in care are unlikely to cause harm unless they are recurrent. For example, occasional missed doses of an antibiotic for a throat infection probably pose no serious risks. Neglect is an issue only when the child's health is clearly in jeopardy. Neglect usually is inferred when there is a pattern of repeated omissions in care. Even a single incident, however, can have devastating effects, such as failure to obtain prompt medical care after a serious head injury. How should a single or rare incident that harms or endangers a child be considered? Although there is a tendency to see single lapses in care as "only human," a definition based on basic needs means that even one incident may constitute neglect.

Incidence

Child neglect usually is not observed; identified and reported cases represent the tip of the iceberg. The best estimate of incidence was made in a study by the US Department of Health and Human Services.² Health care providers, teachers, social

workers, and others were instructed to identify prospectively over a three-month period children who met the study definitions of abuse and neglect. The distribution of children in each neglect category is presented in Table 1. The incidence of the specific forms of neglect is shown in Table 2.

Other forms of medical neglect include malnutrition, lead poisoning, and the increased injuries and illness that are often associated with poverty.⁷

Etiology

The following section pertains to neglect in general, although many of the same factors appear in medical neglect. There has been little prospective research. Some factors may contribute to neglect as well as be characteristic of neglectful families.

There is no single cause for child neglect; rather, there are multiple, interacting factors at several levels that may contribute. For example, maternal depression alone may not lead to neglect, but a developmentally delayed child living with a depressed mother, in poverty with few social supports, is at very high risk for neglect.

Parents. Most research in this area involves mothers because they are more available. Maternal factors that have been associated with neglect include emotional, intellectual, and substance abuse problems.⁸⁻¹⁰ Other maternal characteristics include unrealistic expectations of children, deficient problem-solving skills, poor parenting skills, inadequate knowledge of children's needs,¹¹ and poor maternal nurturing abilities.¹² The limited involvement of many fathers in their children's lives, however, may be a contributory factor, if not a form of neglect per se.

Children. Child characteristics do not appear to play a major role in causing neglect. Some studies, however, have found chronically disabled children¹³ and low birth weight or premature infants¹⁴ to be at increased risk for maltreatment. Increased surveillance of such children may account for the increased identification of maltreatment in some studies.

Family. Problematic parent-child relationships¹⁵ have been found in neglectful families. Kadushin⁹ noted that neglectful mothers may have negative relationships with the fathers of their children.

Community/neighborhood. Parental stress¹⁶ and social isolation¹⁷ have been strongly associated with neglect. A community with ample services such as parenting groups, child care, and public transportation enhances families' nurturing abilities. By contrast, stressful, violent neighborhoods diminish parents' abilities to adequately care for their children.

Table 2. Incidence of specific forms of neglect²

| Form of neglect | Number of children | Rate per 1,000 children |
|-------------------------------|--------------------|-------------------------|
| Refusal of health care | 69,000 | 1.1 |
| Delay in health care | 37,000 | 0.6 |
| Refusal of psychological care | 23,300 | 0.4 |
| Delay in psychological care | 24,800 | 0.4 |

Society. Societal factors can impair families' functioning and ability to care for children, as well as harm children directly. The contribution of poverty to child neglect is particularly striking.¹⁸ The child welfare system—mandated to ensure the adequate care and protection of children—is one example of institutional neglect.¹⁹

Manifestations

Noncompliance with medical care. Failure to comply with health care recommendations or appointments is probably the most common form of medical neglect. In one study, for example, only 25% of the parents of hyperactive children adhered to the treatment plan and fewer than 10% consulted the physician before stopping the medication.²⁰ Noncompliance is not restricted to patients; in terms of not adhering to recognized guidelines, physicians' clinical performance has been rated at 48% to 72% below professional standards.²¹

Several factors may contribute to patient or parental noncompliance. Poor communication between physician and family seems important; the treatment plan may not be understood or the importance of the treatment may not be appreciated. Practical problems include a child's refusal to take a medication or a lack of funds to purchase it. Simply forgetting a dose may be common; remembering three or four doses in a busy day can be a challenge.

Meichenbaum²¹ offers valuable guidance to enhance compliance.

- Name the disorder and the medication.
- Reassure that the treatment should work.
- Review the medication schedule.
- Anticipate problems contributing to noncompliance.
- Probe any concerns.
- Repeat critical points.
- Stress the importance of completing the treatment course.

Other suggestions include putting the treatment plan in writing and making sure the family understands the need for treatment and the plan.

Failure or delay in seeking health care. Parents or primary caregivers frequently decide on the appropriate care for minor ailments. As conditions become more serious, parents are responsible for recognizing the need for professional medical care. Neglect occurs when necessary care is not sought and the child's health is jeopardized.

Factors underpinning such neglect need to be clarified. Parents may be unaware of the seriousness of the condition (e.g., the risk of dehydration in an infant with diarrhea). They may not know that a condition is treatable (e.g., enuresis). The condition may be subtle (e.g., lead poisoning) and go unrecognized. For these reasons, parents should only be considered responsible if a lay person reasonably could be expected to appreciate the need for health care.

Parent and patient education is one way physicians can help prevent medical neglect. For example, explaining the early signs of dehydration or respiratory distress should contribute to parents seeking necessary care for their children. Offering advice about common problems that can be anticipated (e.g., ingestions) is another opportunity to prevent medical neglect. Removing barriers to medical care also is important; practical constraints such as lack of health insurance or transportation may deter parents from seeking health care. Even those with insurance may have restricted access to care for certain conditions.

Failure to thrive (FTT). FTT is often classified as organic (i.e., medical) or nonorganic (i.e., psychosocial) in origin. Nonorganic FTT is a heterogeneous phenomenon with many possible contributors including maternal depression; feeding struggles between mother and infant; maternal ignorance regarding nutritional needs; poverty; and inadequate food.²² Neglect is sometimes inferred in cases of non-organic FTT when the causes have not been clearly identified. Neglect should be a concern when unmet needs (e.g., adequate infant formula) are positively identified as contributing to the poor growth.

A comprehensive understanding of the underlying factors is necessary for appropriate intervention. The first task is to be clear that an infant's growth is deficient, using standard criteria on the growth charts (e.g., weight for height falling below the fifth percentile). The pattern of growth is useful for discerning children who are small, but normal. Where growth is impaired, it is necessary to consider carefully the possible genetic, medical, nutritional, and psychosocial factors that may be contributory.

Initial intervention efforts should support the parent's ability to adequately nurture the child. This might include nutrition counseling, a parenting class, enrollment in WIC, a community health nurse, and referral for mental health services. When such efforts are not successful and the infant's poor growth persists, referral to Child Protective Services (CPS) may be indicated.²²

Religious beliefs. Medical neglect may occur when parents refuse medical treatment for their child based on their religious beliefs. For example, Jehovah's Witnesses refuse surgery when the need for blood transfusions is anticipated. At what point do the child's needs and rights supersede those of their parents' beliefs?

The legal principle *parens patriae* accords the state the right, and duty, to protect the rights of its younger citizens when the parents cannot or will not care for them. However, 44 states, including Maryland, have religious exemptions in their child abuse statutes, such as, "A child is not to be deemed abused or neglected merely because he or she is receiving treatment by spiritual means, through prayer according to the tenets of a recognized religion."²³ These exemptions have been

based on religious groups' arguments that the US Constitution protects religious practice. There are also opposing court rulings and legal opinions that the First Amendment does not sanction harming individuals in the practice of religion.²⁴

Bross²⁵ suggests criteria for assessing whether refusal to obtain care constitutes medical neglect.

1. The treatment refused by the parents should have definite and substantial benefits over the alternative.
2. Not receiving the recommended treatment should result in serious harm.
3. The child is unlikely to enjoy a "high quality" or "normal" life.
4. In the case of adolescents, the youth consents to treatment.

If all criteria are met, a situation of medical neglect exists. The seriousness of the child's condition and the importance of the recommended treatment should be clearly conveyed. The parents' beliefs also should be acknowledged and acceptable compromises should be explored. The legal route is the last resort when attempts to provide adequate treatment have failed.

Drug-exposed newborns. Illicit drugs such as cocaine can harm the fetus and may be associated with long-term neurological sequelae. It has been argued that maternal drug use during pregnancy should be considered a form of child or fetal neglect that constitutes grounds for involving Child Protective Services (CPS).²⁶ The issue, however, is complicated by legal, ethical, and pragmatic considerations. Because child maltreatment laws in Maryland and elsewhere pertain to children, not fetuses, it has been argued that the mother "gave" the child the drug after birth via the umbilical cord. On the other hand, there is concern about infringing on the pregnant woman's rights concerning her own body. There is a shortage of treatment facilities for pregnant drug addicts and there is concern that an approach perceived as punitive (e.g., referral to CPS) may deter women from obtaining prenatal care and drug treatment.

Many health care providers prefer to approach the problem therapeutically, offering appropriate services to mothers and babies.²⁷ Obstetricians can play a valuable role in screening for substance abuse and facilitating referrals for drug treatment. Only if the treatment plan fails and the child remains at significant risk is neglect an issue requiring CPS involvement.

Baby Doe. Infants born with severe handicaps may not receive all available medical care if the parents and/or hospital staff determine the condition to be so serious that it is not compatible with an acceptable life. Although most cases involve infants with severe chromosomal disorders (e.g., Trisomy 18) that are invariably fatal in infancy, others include less severe conditions such as Down syndrome and associated congenital anomalies.

There has been substantial and unresolved controversy regarding circumstances under which life should be supported, and to what extent. The federal *Baby Doe* law suggests that all institutions in which babies are born should have institutional review boards or ethics committees to assist with these decisions.²⁸ Any person concerned that an infant is not receiving necessary care may report the case as medical neglect to CPS. Substantiated reports can lead to legal action mandating care, and a hospital risks losing federal funds for contravening "appropriate" care. In practice, the law appears to have had limited impact; most of these complex decisions continue to be made by parents and physicians.

Evaluation and Management

Medical neglect may be part of a larger picture of neglect in which a child's other basic needs are not met. General principles to guide the evaluation and management of child neglect include:

1. Carefully consider whether the situation meets the criteria for neglect. Has the child's health been harmed or endangered by not receiving the recommended treatment?
2. Consider the immediacy of the harm or endangerment, and the severity of the neglect. Immediate risks and severe neglect may require urgent interventions, including hospitalization, referral to CPS, and court involvement.
3. Develop a clear understanding of what is contributing to the neglectful situation. It is helpful to think of neglect not as a diagnosis, but as a sign or symptom of underlying problems. Appropriate treatment requires understanding these problems.
4. Attempt to have an interdisciplinary approach. Medical, mental health, social work, nursing, and legal input frequently enhances evaluation and management.
5. Begin with the least intrusive approach possible. Successful intervention requires working with families; a respectful approach is crucial.
6. Encourage use of the family's natural and informal supports. For example, inviting fathers to pediatric visits may encourage their involvement in child care.
7. Report to CPS when reasonable efforts have failed or the actual or potential harm to the child is serious. There is enormous heterogeneity among neglectful situations; CPS is one of several resources to strengthen families and protect children.
8. Tailor treatment to the specific needs of child, parents, and family. These needs may be quite varied, such as facilitating enrollment in medical assistance or referring a child or family for counseling. For some families, medical neglect may be just one manifestation of under-

lying dysfunction, and there may be a need for long-term intervention.

Neglect is a serious problem for many children in the United States, with far-reaching ramifications for those affected and for our society. Many factors within and outside families contribute to neglect. The issues are complex and there are no easy solutions. Prevention of child neglect is a compelling goal.

Physicians are in an influential position to help prevent neglect in many different ways, such as educating parents and patients; ensuring that treatment plans are understood; making referrals for drug treatment and other interventions; and advocating for universal access to health care. Advocacy is key to implementing systemic changes to ensure the health and well-being of children. Advocacy can take many forms.²⁹ It may occur at the levels of the individual child and family, the community, or the larger society. It may involve local programs, social policies, and laws. It includes activities such as helping parents cope with their child's disease; improving resources in a community; and writing to legislators on issues concerning children.

References

1. Wolock I, Horowitz B. Child maltreatment as a social problem: The neglect of neglect. *Am J Orthopsychiatry* 1984; 54:530-43.
2. US Department of Health and Human Services. *Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect—1988*. Washington, DC: US Government Printing Office. 1988.
3. Erikson MF, Egeland B, Pianta R. The effects of maltreatment on the development of young children. In: Cicchetti D, Carlson V (eds). *Child Maltreatment*. Cambridge, Massachusetts: Cambridge University Press. 1989; 647-84.
4. Daro D, McCurdy K. *Current Trends in Child Abuse Fatalities and Reporting: The Results of the 1991 50-State Survey*. Chicago, Illinois: National Center for the Prevention of Child Abuse. 1992.
5. Dubowitz H, Black M, Starr RH, Zuravin S. A conceptual definition of child neglect. *Criminal Justice and Psychology* 1993; 20:8-26.
6. Annotated Code of Maryland, Family Law Article 5-701. 1991 Replacement Volume, 1993 Cumulative Supplement.
7. Wise PH, Meyers A. Poverty and child health. *Pediatr Clin North Am* 1988; 35:1169-86.
8. Zuravin S. Child abuse, child neglect, and maternal depression: Is there a connection? In: National Center on Child Abuse and Neglect (ed). *Child Neglect Monograph: Proceedings from a Symposium*. Washington, DC: Clearinghouse on Child Abuse and Neglect Information. 1988.
9. Kadushin A. Neglect in families. In: Nunnally EW, Chilman CS, Cox FM (eds). *Mental Illness, Delinquency, Addictions, and Neglect*. Newbury Park, California: Sage. 1988; 147-66.
10. Jones MA. *Parental Lack of Supervision: Nature and Consequences of a Major Child Neglect Problem*. Washington, DC: Child Welfare League of America. 1987.
11. Azar S, Robinson D, Hekemian E, Twentymen CT. Unrealistic expectations and problem solving ability in maltreating and

- comparison mothers. *J Consult Clin Psychol* 1984; 52:687-91.
12. Aragona JA, Eyberg SM. Neglected children: Mothers' reports of child behavior problems and observed verbal behavior. *Child Dev* 1981; 52:596-602.
13. Diamond LJ, Jaudes PK. Child abuse and the cerebral palsied patient. *Dev Med Child Neurol* 1983; 25:169-74.
14. Herrenkohl EC, Herrenkohl RC. Some antecedents and developmental consequences of child maltreatment. In: Rizley R, Cicchetti D, (eds). *Developmental Perspectives on Child Maltreatment*. San Francisco, California: Jossey-Bass. 1981; 57-76.
15. Crittenden PM. Maltreated infants: Vulnerability and resilience. *J Child Psychol Psychiatry* 1985; 26:86-96.
16. Gaines R, Sandgrund A, Green A, et al. Etiological factors in child maltreatment: A multivariate study of abusing, neglecting, and normal mothers. *J Abnorm Psychol* 1987; 87:531-40.
17. Polansky NA, Ammons PW, Gaudin JM. Loneliness and isolation in child neglect. *Social Casework* 1985; 66:38-47.
18. American Human Association. *Highlights of Official Child Abuse and Neglect Reporting, 1983*. Denver, Colorado: American Human Association. 1985.
19. National Advisory Board on Child Abuse and Neglect. *Creating Caring Communities: Blueprint For Effective Federal Policy on Child Abuse and Neglect*. Washington, DC: US Department of Health and Human Services. 1991.
20. Firestone P, Witt JE. Characteristics of families completing and prematurely discontinuing a behavioral parent-training program. *Pediatric Psychology* 1982; 7:209-22.
21. Meichenbaum D. Non-compliance. In: *Feelings and Their Medical Significance* 1989; 31;(2):4-8.
22. Bithoney WG, Dubowitz H, Egan H. Non-organic failure to thrive. *Pediatr Rev* 1992; 13:453-59.
23. American Academy of Pediatrics, Committee on Bioethics. Religious exemptions from child abuse statutes. *Pediatrics* 1988; 81:169-71.
24. *Jehovah's Witnesses of Washington v King County Hospital*. 278 F Supp 488 (Washington, DC 1967), affirmed per curiam 390 US 598. 1968.
25. Bross DC. Medical care neglect. *Child Abuse Negl* 1982; 6:375-81.
26. McCullough CB. The Child Welfare League Response. In: *The Future of Children: Drug Exposed Infants*. Los Altos, California: Center for the Future of Children. 1991.
27. Larson CS. Overview of state legislative and judicial responses. In: *The Future of Children: Drug Exposed Infants*. Los Altos, California: Center for the Future of Children. 1991.
28. US Department of Health and Human Services. *Child Abuse Amendment of 1984*. (Pub L.98-457). Federal Register, April 15, 1985.
29. Dubowitz H. Pediatrician's role in preventing child maltreatment. *Pediatr Clin North Am* 1990; 37:989-1002.

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Sexual abuse of children—a primer for physicians

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ABSTRACT: *Sexual abuse of children is a problem that can present to any physician at any time. This article provides basic information about child sexual abuse and instructs physicians how to respond to abuse victims in a professionally responsible way that assures that the child is supported and protected. Legal definitions, prevalence, epidemiology, evaluation approaches, psychological problems, interviewing, the physical examination, sexually transmitted diseases, and management issues are discussed with emphasis on the physician's role. Finally, prevention is mentioned as the only real solution to this problem.*

Identifying sexually abused children

Definition. Under Maryland law, sexual abuse is any act that involves sexual molestation or exploitation of a child by a parent, by another person who has permanent or temporary care or custody or responsibility for supervision of the child, or by a household or family member. If the act is perpetrated by someone who is not a member of the household or family, it is considered sexual assault.

Sexual abuse/assault includes, but is not limited to, contact or conduct with a child for the purpose of sexual gratification. Acts may range from sexual advances, kissing, or fondling, to sexual crime in any degree. Sexual crimes include rape; sodomy; prostitution; or allowing, permitting, encouraging, or engaging in the obscene or pornographic display, photographing, filming, or depiction of a child as prohibited by law. Rape occurs when physical force, threats, or drugs are used to achieve sexual intercourse. Statutory, or second degree rape, is vaginal intercourse with a person under age 14, if the person performing the act is at least four years older.

Prevalence and epidemiology. Reported cases of child sexual abuse represent the tip of the iceberg. Retrospective studies indicate that 19% to 38% of girls, and 5% to 15% of boys are sexually abused or assaulted during childhood. Peak ages for sexual abuse of girls are five to six, and fourteen to fifteen. For boys, peak ages for abuse are six to seven.

Table 1. Psychological problems associated with child sexual abuse

| | |
|-------------------------|--|
| Traumatic Sexual | |
| Experience: | <i>precocious sexual activity</i> sexual aggression compulsive masturbation promiscuity prostitution |
| Betrayal: | <i>anger</i> <i>depression</i> <i>grief</i> impaired ability to trust |
| Powerlessness: | <i>anxiety, hypervigilance</i> <i>fear, phobia, nightmares</i> <i>aggressive behavior</i> perception of self as victim vulnerability to further abuse vulnerability to perpetrating abuse |
| Stigmatization: | <i>guilt, shame</i> lowered self-esteem social isolation suicidal ideation |

Perpetrator characteristics. Although there is no typical profile, most perpetrators are males who were themselves abused as children; 20% to 40% are adolescents. Perpetrators are likely to appear normal and successful, and unlikely to have prior criminal records. Most perpetrators are not strangers; they often are known to the child and enjoy a position of trust and authority with the child.

With younger children, fondling is the most common form of abuse. Intercourse is more common with older children. The perpetrator is likely to use some form of coercion, such as bribes, threats, or force.

Psychological characteristics. The psychological problems associated with sexual abuse are theorized to result from four main areas: a traumatic sexual experience; a sense of betrayal by one or more trusted persons; the feeling of powerlessness to protect oneself; and the stigma of having been abused. In Table 1, italicized problems are often experienced in the first one to two years following the abuse; the other problems are more long-term. Most of the problems, however, are not specific to sexual abuse.

Detecting medical problems

Any child suspected of having been sexually abused should have a medical evaluation. The goals of this evaluation are:

- to identify abused children;
- to detect and manage medical problems;
- to detect and address psychosocial problems;
- to gather forensic evidence;

- to help ensure the child's safety and protection;
- to facilitate appropriate referrals for further evaluation, medical follow-up, and mental health services.

Many children disclose their abuse some time after it occurred; for these children, assessment is not a medical emergency. Although these children do not require urgent evaluation in an emergency department, they should have a screening evaluation by a primary care provider and be referred for consultation or treatment, if needed. In determining the appropriate time for a screening evaluation, the child's emotional state, the possibility of obtaining forensic evidence (e.g., sperm is present for three days), and the expertise of the examiner should be considered. Abuse cases must be reported to Child Protective Services (CPS) and police, if appropriate.

Urgent evaluation, preferably in a pediatric emergency department and designated sexual assault center, is indicated when the child may have been abused within the previous three days; there are major medical problems (e.g., bleeding); and/or there are major psychological problems (e.g., suicide threat).

The interview is the first step used when conducting an evaluation. If possible, the child and caregiver(s) should be interviewed separately in a safe, quiet, comfortable room.

Caregiver interview. Ask about:

- prior interviews and assessments; it is important to clarify whether and to what extent CPS and police are involved;
- prior history of maltreatment;
- disclosure history (to whom, under what circumstances);
- medical history related to suspected abuse (e.g., genitourinary symptoms);
- family situation (household members, sleeping and baby-sitting arrangements, exposure to sexual activity/materials, substance abuse, domestic violence); and
- the caregiver's response to alleged abuse (feelings, actions).

Child interview. The purpose of the interview is to gather specific details about the abuse. It is very important, however, to build rapport with the child. Several techniques can be helpful.

- Encourage the child to participate; invite questions.
- Tell the child it is OK to ask for clarification of a question, to decline to answer a question, or not to know the answer to a question.
- Let the child know that some questions may be asked more than once.
- Praise the child for helping, both during and after the interview.
- For older children, confidentiality is an issue; be realistic and honest.

The use of language, by both the child and the interviewer, also is important. The interviewer should

- observe body language and mood shifts;

- assess the child's developmental level, particularly language;
- find out the child's terms for genitalia, perhaps on a drawing;
- begin with open-ended questions; multiple-choice may be helpful;
- avoid leading and yes-no questions;
- avoid why questions; they may suggest blame;
- with young children, ask who, what, where;
- with older children, add when, how;
- use simple tenses and one-word verbs, e.g., who touched you?;
- use names rather than pronouns, e.g., what did John do?;
- use active voice rather than passive voice, for example
Who touched you?
Where?
How many times?
How did it feel?
What were you wearing?
What was he/she wearing?
What did you say and do?
What did he/she say and do?
Was anyone else there?
Did he/she touch anyone else?;
- obtain a sexual history in postpubertal children; and
- prepare the child for what will happen next.

The physical examination. The first evaluation following sexual abuse may be frightening and stressful. Repeated questioning by physicians, social workers, psychologists, protective service workers, and police, in addition to a physical exam, may add to the trauma. Although it is essential to obtain clear information, it is equally important to protect the patient from further psychological trauma. A physician with a trusted relationship is in a unique position to provide support and to gain information not easily obtained by the others involved. The physician should act as a patient advocate and liaison between the victim and police, other health care professionals, and the patient's family.

In addition to being attentive and sensitive to the child's needs, the physician must be sensitive to needs of the parents and family. Family members may have a range of reactions, including guilt, anger, agitation, and feelings of helplessness. They may require as much support and reassurance as the victim. A separate interview with the parents may help alleviate some of their worries. With assistance, most parents will be able to provide much needed support to the victim.

The initial contact should be supportive and not painful. Detailed history taking may be deferred to a later time, if necessary. The patient and family should be informed in understandable terms of the purpose and goals of the evaluation. They should be told of tests, procedures, and the nature of the intended physical examination. For example, prepubertal children and their parents should be told that an internal

gynecologic examination will not be done, since it is rarely necessary.

The child should be allowed as much control as possible, including a choice of who is present during the examination. The child should be encouraged to ask questions and invited to participate/assist in the examination. Suitable coverings should be used to protect the child's modesty.

At the most, minimal restraint should be used. The child may be helped by holding a parent's hand, or a nurse gently keeping the legs open. Forcing an examination upon a distraught, struggling child is unacceptable. If the child is or becomes too frightened to cooperate, options may include finding an examiner of the same sex as the child; prioritizing parts of the examination based on the history; having the child seen by a more experienced examiner; or scheduling an examination under anesthesia.

Internal vaginal examinations in prepubertal girls and rectal examinations are rarely needed. They should be done, usually under anesthesia, only if internal injuries are suspected.

Girls. Examination of the genitalia is best done in the supine (frog-leg) position. The prone knee-chest position may reveal a very different picture and can be useful when the supine examination appears equivocal. External genitalia are visualized by gentle lateral and posterior traction, just lateral to the labia majora. Another method is to gently hold each labium majora between thumb and index finger and to pull upwards.

The child's physical development (Tanner stage) should be noted. The physician should examine for signs of acute trauma (e.g., abrasions), old trauma (e.g., discontinuity of the hymen; areas where the hymen appears to be missing), and infection (e.g., discharge).

Although the transverse diameter of the hymenal opening should be noted, there are many normal variations. Its appearance and the diameter of the vaginal opening may change depending on the child's state of relaxation or position. Without other abnormal findings, the size of the hymen rarely is indicative of sexual abuse.

Boys. The penis and scrotum should be examined for signs of acute or old trauma, as well as for infection. The child's Tanner stage should be noted.

Anal examination (boys and girls). The child may be examined in the supine position with knees drawn to the chest; in the prone knee-chest position; or in the lateral position with knees drawn to the chest. The examiner should note signs of acute trauma (e.g., bruising), old trauma (e.g., gaping equal to or greater than 10mm), or infection. A digital rectal examination is rarely needed. Anoscopy may be done if there is active bleeding.

Interpreting the examination. A normal examination does not rule out sexual abuse; evidence of abuse may not be found in many abused children. Suggested descriptions of an examination's findings include

- normal, including normal variations; does not exclude the possibility of sexual abuse;

- equivocal/uncertain;
- abnormal, consistent with abuse;
- abnormal, indicative of abuse; or
- abnormal, not due to abuse.

Sexually transmitted diseases. Children may have a sexually transmitted disease (STD), but be entirely asymptomatic with a normal examination. In addition, the history of sexual abuse may be incomplete, particularly because the child may not disclose everything that happened. There is no consensus as to which laboratory tests should be done under various circumstances. Factors that should be taken into consideration include

- local STD epidemiology;
- perpetrator characteristics (e.g., known drug user);
- type of abuse (e.g., genital-genital contact);
- time elapsed since abuse occurred;
- signs or symptoms of abuse (e.g., hymenal tear);
- signs or symptoms of STDs (e.g., discharge);
- complications of missing an STD diagnosis;
- forensic issues (e.g., will test results be usable in court?);
- traumatic effect on child (e.g., discomfort associated with obtaining cultures); and
- child and family concerns (e.g., anxiety about STDs).

Laboratory tests do not have 100% sensitivity and specificity. For example, gonococcus (GC) is a fastidious organism and cultures may be negative under the wrong conditions. Deoxyribonucleic acid (DNA) probes may result in false negatives and false positives, especially for *Chlamydia*. STDs may be transmitted perinatally and there may be a long latency period—up to three or more years for *Chlamydia*; two to three years for human papilloma virus (HPV); and several years for human immunodeficiency virus (HIV). If there is concern that a STD is present, follow-up cultures may be needed, since initial results might reflect sexual contact prior to abuse. The possibility of sexual activity distinct from abuse in pubertal and older children clearly needs to be considered. Findings indicative of probable and certain child sexual abuse are listed in Table 2.

Table 2. Interpreting STDs in relation to sexual abuse

Certain abuse

- ◆ Gonococcus (GC), beyond the neonatal period
- ◆ Syphilis, beyond age three months (primary) to first year (secondary)
- ◆ Human immunodeficiency virus (HIV), if transmission perinatally or via blood transfusion can be excluded

Probable abuse

- ◆ *Trichomonas vaginalis*
- ◆ Genital herpes, particularly type II
- ◆ Condylomata acuminata, especially beyond two to three years of age
- ◆ Anogenital *Chlamydia*, beyond age three, culture proven
- ◆ Hepatitis B, if transmission perinatally or via blood transfusion can be excluded

Treating medical problems

Following the child and caregiver interviews, physical examination, and laboratory testing, the physician should integrate all the available information and provide a brief summary of the assessment. Terms such as “possible” and “probable” may be used, but “risk of sexual abuse” should be avoided. After making a diagnosis of sexual abuse, the physician should treat associated medical problems.

Sexually transmitted diseases. The risk of acquiring STDs after sexual abuse is low. Acute or prophylactic treatment of a STD is not recommended unless the patient is symptomatic, has been assaulted by multiple abusers, or has been abused by someone with a STD. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* cause most STDs in sexually abused children.

Because treatment can fail, all treated patients should be seen for follow-up cultures one week after the end of the treatment course. If the victim is determined to be at significant risk for the development of a STD and has presented for care within several days of the assault, care must be taken to consider the incubation periods of the offending organisms. It is recommended that these patients return one week after the assault for *Chlamydia* and GC testing.

Syphilis. Patients should be tested for syphilis if they are positive for any other STD, or an initial screening with GC and *Chlamydia* studies. Syphilis screening (nontreponemal testing) should be performed at that time and again four to six weeks later if the initial study is negative. A treponemal test should be performed to confirm a positive nontreponemal result. The incubation period for syphilis is usually about three weeks, but may range from ten to ninety days.

Hepatitis. If the perpetrator is a known or suspected carrier (e.g., a known intravenous drug user) of hepatitis B surface antigen, the child should receive hepatitis B immune globulin within fourteen days of the assault and should be tested at the time and again three months later. The hepatitis B vaccine series also should be started at presentation.

HIV. If the perpetrator is a known or suspected carrier of HIV, the child should be tested serologically at the time of presentation and again 12 to 24 weeks after the assault.

Others. Evaluation for the presence of herpes simplex virus, human papillomavirus, *Trichomonas vaginalis*, and other possible STDs should be guided by symptomatology (e.g., the presence of a vaginal discharge, genital or rectal warts, or vesicular lesions). Several organisms associated with sexual transmission can be found in children who have not been sexually abused. These include *Gardnerella vaginalis* (Bacterial vaginosis), *Mycoplasma hominis*, *Ureaplasma urealyticum*, and *Haemophilus ducreyi*.

Physical injuries. Many sexually abused children sustain no apparent physical injury. Superficial injuries such as bruises, abrasions, irritation, and edema resolve quickly and require no treatment. Sitz baths may help remove secretions. Patients with more extensive abrasions require specific attention to hygiene to prevent secondary infections. Vulvar hematomas should be treated with ice and pressure. Perineal and intravaginal lacerations requiring suturing should be done with heavy sedation or under general anesthesia. Bite wounds should be irrigated and debrided carefully and allowed to heal secondarily; antitetanus immunization and antibiotic treatment should be considered.

Pregnancy. Pregnancy as a result of rape is a potentially preventable tragedy. The use of drugs to prevent pregnancy in rape victims, however, is controversial for several reasons that should be shared with all patients.

- The likelihood of pregnancy after rape is extremely low, lower than predicted from single acts of intercourse. The probability of conception varies with the days of the victim's menstrual cycle. More than six days before and more than four days after ovulation, risk is negligible (less than 0.05%). Risk is highest from three days before to the day of ovulation (14% to 17%). Because ovulation days are difficult to identify, the use of drugs to prevent pregnancy should be discussed with every postmenarchal rape victim who is seen within seventy-two hours of the event.
- A small failure rate (2%) exists with these drugs.
- The teratogenic potential is unclear. The absence of a preexisting pregnancy should be established by doing a pregnancy test before a pregnancy prevention drug is used.
- Side effects such as severe nausea and vomiting may lead to noncompliance.

Estrogens have been used successfully to prevent pregnancy secondary to rape. They presumably act by preventing implantation of the blastocyst in the endometrium. Recommended drugs and regimens are shown in Table 3. Menstruation follows treatment within twenty-one days in 95% of patients. Follow-up should be arranged.

If the patient presents seventy-two or more hours after the rape, pregnancy prevention drugs should not be used. All alternatives should be explored with the patient and family, and their decision should be supported. Appropriate follow-up care should be arranged.

Protecting against further abuse

After diagnosing possible or probable sexual abuse, and identifying and treating associated medical problems, the physician should take steps to protect the child from further abuse.

Table 3. Use of estrogens to prevent pregnancy

Ovral (ethinyl estradiol and dl-norgestrel)

- ◆ 2 tablets by mouth every 12 hours for 2 doses beginning within 72 hours of the rape
- or
- ◆ 1 tablet by mouth every 3 hours for 4 doses beginning within 72 hours of the rape

Ethinyl estradiol

- ◆ 5 mg by mouth every day for 5 days starting within 72 hours of the rape

- Report the abuse to CPS.
- Report the abuse to local law enforcement officials (in Maryland, CPS will do this).
- Educate the caretaker to maintain open communication with the victim, to recognize signs and symptoms of sexual abuse, and to try to prevent high risk situations.
- Educate the victim to maintain open communication with the caretaker, and to understand that it is OK to say no.

Psychosocial support. All children who have been sexually abused should be evaluated by an experienced mental health care provider. The need for treatment varies with the supportiveness of the parents; the type of abuse; whether the abuser is known to the patient; and the length of time the child has been abused. More pronounced symptomatology has been found when abuse was prolonged, frequent, more intrusive in nature, and perpetrated by a closely related person. In such cases, the child has a worse prognosis, and may require long-term treatment. The parents and family of sexually abused children also may need treatment and support.

Cooperation with public agencies. The reporting physician often serves as a consultant during the CPS and police investigations; he or she should summarize the medical data, interpret the findings, and advocate for appropriate follow-up care and intervention. Public agencies can provide valuable support services to pediatricians, children, and families.

Continued follow-up. Pediatric follow-up is essential for the child and family. The pediatrician should monitor for delayed symptomatology, provide needed ongoing support, and act as a liaison between the involved agencies and the family.


Suggested Readings

1. Berkowitz C. Child sexual abuse. *Pediatrics in Review* 1992; 13 (12):443-52.
2. Heger A, Evans SJ. *Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas*. New York: Oxford University Press. 1992.
3. Chadwick D, Berkowitz C, Kerns DL, McCann JJ, Reinhart MA, Strickland, S. *Color Atlas of Child Sexual Abuse*. Chicago: Year Book Medical Publishers, Inc. 1989.

Acknowledgement

The author wishes to thank Drs. Howard Dubowitz and Joann Lanzo for their assistance. ■

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Child abuse and wife abuse: the connections

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ABSTRACT: *Wife abuse and child abuse frequently are inter-connected. Survey and other data indicate abused children are likely to have abused mothers, and abused mothers are likely to have abused children. Physicians often can be more effective in protecting abused children by recognizing that the mother also may need protection.*

There are significant, complex connections between wife abuse and child abuse that have important implications for the health care system. In one medical record review of abused children, 59% of the mothers had histories of injuries indicative of wife abuse.¹ In another medical record review, Stark and Flitcraft² found battered women were six times more likely than nonbattered women to have children reported for child abuse. The father or father figure was three times more likely to be the child's abuser compared with families without wife abuse. Approximately 50% of the abused children were abused by the man, 35% by the battered woman, and the rest by others or both partners. In a national random survey, Straus et al.³ found a substantive correlation between wife abuse and child abuse; both partners were more likely to abuse their children than families without wife abuse. When wife abuse was severe, 77% of the children also had been abused at some time during their lives.⁴ In a sample of 200 substantiated child abuse cases in Massachusetts, 30% included documented abuse of the mother. This is undoubtedly an underestimate as caseworkers did not routinely ask about wife abuse at the time.

A related phenomenon is abuse during pregnancy. A number of researchers have found that 8% to 16% of women are physically or sexually abused by their intimate partner during pregnancy.^{5,6} In an in-depth interview study of 79 battered women, 27 reported being abused during pregnancy; of these, 5 indicated the abuser seemed to be directing the violence toward the unborn child, actually trying to cause a miscarriage.⁷ In another study of battering during pregnancy, Helton found evidence that the majority of abusive

injuries were directed toward the pregnant abdomen rather than other parts of the body.⁸ Such abuse presents a danger to the child both before and after birth. Men who abuse their partners during pregnancy in an effort to harm the unborn child or because of anger about the pregnancy can be predicted to be potential child abusers after the child is born. The American College of Obstetrics and Gynecology recommends assessing all pregnant women for abuse. When pregnant abused women are identified, their children should be considered at risk for child abuse.

Mothers of abused children traditionally have been considered villains, not victims. Health care professionals, as well as the general public, tend to interpret a woman's continued relationship with a man who harms her children as at worst, complicity, at best, failure to protect. Health care professionals fail to understand the complex circumstances, the serious danger if the woman leaves, and the effects of abuse on the woman's physical and mental health that all interact to make escape extremely difficult. In many cases, the woman does the best she can to protect her children, even taking many of the blows that otherwise would land on the children. The majority of battered women eventually do leave the abusive relationship or manage to make the violence end, but it may take several years for them to do so.

The health care system can be instrumental in preventing or alleviating wife and child abuse. Whenever a woman is identified as a victim of wife abuse, her children should be considered at risk for child abuse. Conversely, when a child is reported for abuse, there should be an automatic query about the safety of the mother.

By providing in-depth assessment, referrals, and appropriate counseling, physicians can help a woman abused during pregnancy realize that there are options and that the abuse is unlikely to end with the birth of the child. Pregnancy is an especially useful time for intervention because the abuse usually is relatively new in the relationship rather than an entrenched pattern. Because pregnancy is also a time when the woman is seen frequently by health care professionals, it offers the opportunity for systematic follow-up and establishment of rapport.

For the mother of an abused child who is being abused herself, more in-depth interventions are needed. A wife batterer who also abuses the child is extremely dangerous. My research indicates child abuse is one of the risk factors for eventual homicide in the battering relationship. A battered woman is most at risk for homicide when she actually leaves the abusive relationship or makes it clear to the man that she is leaving for good. Thus, if she wants to leave, careful arrangements must be made with the local wife abuse shelter or police to assure her safety. While still with the abuser and considering her options, she needs an exit plan—an emergency plan of action that includes a safe place to go, a little money stashed away along

with important papers, and a procedure worked out with the children so they can get away quickly if necessary.

Some hospitals have found that ordinary medical, nursing, and social services are inadequate to address the complex issues of child abuse when the mother is also being battered. Children's Hospital of Boston pioneered the *AWAKE* advocacy program to protect children by protecting their mothers. Each mother of a child reported for child abuse is assessed for wife abuse and assigned an advocate if she is battered. The advocate helps the mother with parenting skills, negotiating with the criminal justice system for an order of protection or other actions against her abuser if desired, linkage with other services for battered women, and assistance in obtaining needed health services for the woman and all the children in the home.

Even without such a formalized program, all physicians, nurses, and medical social workers who work with abused children need to be informed about the connections between wife abuse and child abuse. They need to understand the realities for abused women and how to help them without victimizing them further. They need to learn how to brainstorm with abused women about their options, rather than being paternalistic. Abused children often can be protected by protecting their mothers.

References

1. McKibben L, De Vos E, Newberger E. Victimization of mothers of abused children: a controlled study. *Pediatrics* 1989; 4:531.
2. Stark E, Flitcraft AH. Women and children at risk: a feminist perspective on child abuse. *Int J Health Serv* 1988; 18:97-119.
3. Straus MA, Gelles RJ. *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families*. New Brunswick: Transaction Publishers. 1990.
4. Strauss M, Gelles R, Steinmetz K. *Behind Closed Doors: Violence in the American Family*. Garden City: Anchor Books. 1980.
5. Campbell JC, Poland M, Ager J, Waller J. Correlates of battering during pregnancy. *Res Nurs Health* 1992; 15:219-26.
6. McFarlane J, Parker B, Soeken K, Bullock L. Assessing for abuse during pregnancy: severity and frequency of injuries and associated entry into prenatal care. *JAMA* 1992; 267:3176-98.
7. Campbell JC, Oliver C, Bullock L. Why battering during pregnancy? *AWHONN's Clinical Issues in Perinatal and Health Nursing* 1993; 4:343-49.
8. Helton AS. Battering during pregnancy. *Am J Nurs* 1986; 86:910-13. ■

Family violence and the adolescent

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ABSTRACT: *Violence within the family may have a major impact on child and adolescent development. Abused adolescents are more likely to engage in high-risk behaviors with serious consequences. Current adolescent health care is often inadequate in terms of psychosocial screening and anticipatory guidance. Physicians may play a significant role in reducing and preventing adolescent-related violence by increasing their efforts to identify those at risk and helping them with appropriate interventions.*

Family violence may have a major impact on the well-being of the adolescent and the outcome of adolescent development. By understanding the role of the family in supporting the child through adolescence and by appreciating that family violence is both an indicator and cause of serious family dysfunction, physicians may be able to play a key role in intervention.

According to a survey of married couples, domestic violence occurs in one of four American families.¹ Risk is greater in settings of separation or divorce and between unmarried intimate couples. Each year, 10 million American children witness physical violence between their parents.² Because of the magnitude of the problem and the impact on children in terms of high-risk behavior, physicians should screen all patients, including adolescents, with respect to violence and abuse in the family setting, in current relationships, and in the family of origin.

Developmental tasks and the role of the family

Adolescence, a period of particular vulnerability, is that phase of development during which the child becomes an adult capable of independent survival. The transition occurs as the adolescent masters a particular set of psychosocial tasks in preparation for adulthood. These tasks include establishing an identity and positive self-image; acquiring control of impulses and drives; participating in peer relationships and activities; develop-

ing a capacity for abstract thinking; and acquiring a value system.³ Teenagers accomplish these tasks by experimenting and taking risks; it is developmentally appropriate for them to do so. Nature and nurture are important factors that determine how much risk-taking occurs. The family's role is to provide both. Beyond genetic contributions, families offer food, shelter, and safety. Within the family, children learn about roles and relationships. Families guide, discipline, and model values and behaviors. When the family fails to perform its role, it is considered dysfunctional.⁴ Violence in the family is a major contributor to family dysfunction, and its impact on child and adolescent development may be significant.

Child abuse and corporal punishment

When a child is the target of abuse in the family, the family has failed its obligations to protect and nurture. Not only is the child at risk for bodily injury, he or she is vulnerable to emotional and developmental problems. Corporal punishment, a common form of interpersonal violence, is one example. Although it may be sanctioned in society by parents, schools, and even healthcare providers,^{5,6} its potential for damage must be examined. The goal of corporal punishment, ostensibly to teach, is really to control the behavior of another by inflicting or threatening to inflict pain. Children learn that this is an acceptable means to control the behavior of others, rather than developing other methods of negotiation and problem solving. Furthermore, the child is motivated by avoidance of painful consequences, rather than by more sophisticated value systems and moral codes.⁶

The more punitive and aggressive the parenting, the greater the risk of significant psychosocial problems, including antisocial behavior.⁷ In the setting of child abuse and cruelty, children fail to learn empathy;⁸ instead, they learn violence. Adolescence is a period of great risk for abuse. According to a national study of the incidence and severity of child abuse and neglect, adolescents were abused more often and more severely than other children, and the abuse resulted in a greater number of fatalities.⁹ This can be explained by understanding that violence, a means of control, will be relied upon more often as the teenager attempts to separate from parental control. In two national surveys, Strauss^{10,11} found that half the adolescents ages 16 to 17 reported being hit until they left home.

Even when violence is perpetrated by adults only against adults, children are victimized. Their response to violence is a function of age, how close they are to the event or the victim, and the presence of a nurturing adult capable of helping them cope.¹² In domestic violence, the victims and perpetrators are the parents. As a result, that support is not available and the child's immediate world is unsafe. Patterns of response include hypervigilance, high-risk behavior, and formation of inappropriate attachments.¹³ If not resolved by adolescence, these responses will not only impair the teenager's ability to negotiate

successfully the tasks previously outlined, they will place him or her at greater risk of mortality.

Epidemiology

Survival trends for adolescents are alarming. Homicide data indicate adolescent violence is epidemic. Homicide is the second leading cause of death for all young men and the leading cause of death for African-American males ages 18 to 24.¹⁴ Accidents, suicide, and homicide account for 75% of all deaths in adolescents. Malignancy and heart disease are the fourth and fifth leading causes.¹⁵

The *National Adolescent Student Health Survey*¹⁶ revealed the degree to which adolescents engage in high-risk behaviors and the outcomes of those behaviors. Adolescents are disproportionately the victims of crime and assaults: 49% of boys and 28% of girls reported involvement in a physical fight during the previous year; 64% of boys and 19% of girls reported having used a gun, and 33% knew where to get one; 42% of girls had considered suicide and 12% had tried to injure themselves. In addition, 26% of 10th graders were current smokers, 89% had used alcohol, 35% had used marijuana, and 8% had used cocaine. Finally, 61% of girls reported having dieted; methods included diet pills (16%), vomiting (12%), and laxatives (8%). According to Heyse¹⁷ and the Centers for Disease Control,¹⁸ 800,000 American teenagers became pregnant in 1987, and 2.5 million had sexually transmitted diseases. Today, acquired immunodeficiency syndrome (AIDS) is the sixth leading cause of death among teenagers in this country.

Prevention

In light of these data, the primary care of adolescents must be reevaluated. Adolescent health care often consists of the 15-minute school or sports physical examination, a low-yield endeavor in which evaluation is focused briefly on the physical status of an asymptomatic youth. Although many physicians understand the importance of psychosocial screening and anticipatory guidance for teenagers, the opportunity to conduct such screening seems infrequent.

New strategies to address the health risks of adolescents are outlined in the recently published American Medical Association (AMA) *Guidelines for Adolescent Preventive Services*.¹⁹ The document provides comprehensive recommendations to promote parenting education, adolescent adjustment, and safety and injury prevention. Recommendations also address ways to prevent drug abuse; physical, sexual, and emotional abuse; and mental health problems.

Physicians may play a significant role in implementing the guidelines through practice-, hospital-, and community-based interventions. Routine assessments of psychosocial issues should be included in standard protocols. Anticipatory guidance should include education about adolescent development and effective nonviolent techniques for coping with adolescent

behaviors. The infant immunization series helps motivate parents to return, thus providing physicians the opportunity to reinforce education and prevention in early childhood. In a similar way, return visits for hepatitis immunizations, follow-up visits to evaluate contraception, and even the sports physical can be restructured to focus clearly on the issues that put adolescents at greatest risk: dysfunctional families, high-risk behavior, and exposure to violence. Adolescents who are victims or at great risk for intentional or unintentional injury should be identified and, when necessary, referred.²⁰

When injuries are present, hospital- and practice-based interventions should include routine assessment of the circumstances of the event; the presence of substance abuse; biological or psychosocial risk factors; the relationship between perpetrator and victim; and past history and future risk of violent behavior, including revenge. Hospitals should establish intervention protocols and services for victims of family and street violence similar to those developed for child abuse and sexual assault.²¹

Since violence is also a public health issue, community-based interventions ultimately may have the greatest impact. Physicians should participate in defining objectives and in lobbying for support of community efforts such as community service programs, support groups, mental health services, and school-based education programs. We must demand that the criminal justice system respond appropriately. We must work to reduce access to weapons and exposure to media violence. We must appreciate that, to the struggling adolescent, gang membership seems to be an appropriate alternative when the family, schools, and community fail.

In summary, physicians may play a role in reducing the incidence of violence toward the young by (1) accepting that violence is a public health issue; (2) devising a method to screen for violence in patient encounters; (3) incorporating violence prevention in anticipatory guidance; (4) assisting hospitals to establish intervention protocols for family violence; and (5) working with community leaders to eliminate neighborhood violence.

References

1. Randall T. Domestic violence begets other problems of which physicians must be aware to be effective. *JAMA* 1990; 264:940-4.
2. Gilles R, Straus MA. *Intimate Violence*. New York: Simon and Schuster. 1988.
3. Felice M. Adolescence. In: Levine M, Carey W, Crocker A (eds). *Behavioral Pediatrics*. Philadelphia: WB Saunders. 1992.
4. Ludwig S, Rostain A. Family function and dysfunction. In: Levine M, Carey W, Crocker A (eds). *Behavioral Pediatrics*. Philadelphia: WB Saunders. 1992.
5. Orentlicher D. Corporal punishment in the schools. *JAMA* 1992; 267:3205-08.
6. McCormick K. Attitudes of primary care physicians toward corporal punishment. *JAMA* 1992; 267:3161-65.
7. McCord J. Parental behavior in the cycle of aggression. *Psychiatry* 1988; 51:14-23.
8. Straus MA. Children as witness to marital violence, a risk factor for lifelong problems among a nationally representative sample of American men and women. *Ross Roundtable Report—Children and Violence* 1992; 98-104.
9. National Center on Child Abuse and Neglect, Executive Summary 1992.
10. Straus MA, Gelles RJ. *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families*. New Brunswick, New Jersey: Transaction Publishers. 1990.
11. Straus MA, Gelles RJ, Steinmetz SK. *Behind Closed Doors: Violence in the American Family*. Newbury Park, California: Sage. 1990.
12. Groves BM, Zuckerman B, Marans S, Cohen DJ. Silent victims, children who witness violence. *JAMA* 1993; 269:262-64.
13. Lyons JA. Post-traumatic stress disorders in children and adolescents: a review of the literature. In: Chess A, Thomas A (eds). *Annual Progress in Child Psychiatry and Child Development*. New York: Brunner Mazel. 1987; 451-67.
14. Centers for Disease Control. Violent deaths among persons 15-24 years of age—United States, 1970-79. *MMWR Morb Mortal Wkly Rep* 1982; 32:453-57.
15. Joffe A. Adolescent suicide, homicide, and unintentional injuries. *Md Med J* 1988; 37:955-58.
16. Leads from the *MMWR*. Results from the National Adolescent Student Health Survey. *JAMA* 1989; 261:2025-31.
17. Hayes C (ed). *Risking the Future: Adolescent Sexuality, Pregnancy, and Child Bearing*. Vol I, Final Report. Washington, DC: National Academy Press. 1987.
18. Centers for Disease Control. Center for Prevention Services, Division of Sexually Transmitted Diseases, Annual Report—FY 1988. Atlanta: US Department of Health and Human Services, Public Health Service. 1989.
19. Elster A, Kuznets N. *AMA Guidelines for Adolescent Preventive Services*. 1993.
20. Stringham P, Weitman M. Violence counseling in the routine health care of adolescents. *J Adolesc Health Care* 1988; 9:389-93.
21. Prothrow-Stith D. Can physicians help curb adolescent violence? *Hosp Pract* 1992; 27(6):193-196, 199, 202, 207. ■

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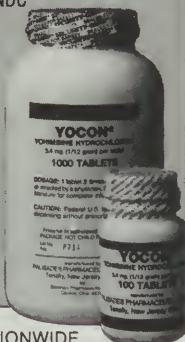
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Children: the secondary victims of domestic violence

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ABSTRACT: *Children who grow up in violent households can easily become the next generation of victims of violence or perpetrators of violence. Recognizing and responding to the special needs of children who witness domestic violence is essential in any effort to reduce or prevent cycles of abuse. As physicians focus on domestic violence, they are in a key position to identify children who are symptomatic from witnessing trauma and to make appropriate referrals.*

“Children learn what they live” is a well known maxim that encourages parents to consider the effects of their behavior on children. Children who witness domestic violence are no exception to learning from what they experience. They often grow up exhibiting the same violent behaviors as their parents. That patterns of violent behavior may be passed from one generation to the next has been substantiated by family violence researchers.¹ An estimated 30% of those who witness violence in their homes become perpetrators of violence. This is considerably higher than the abuse rate of 2% to 4% found for children in the general population.¹

Children in violent homes receive the message that violence is an effective means of gaining control over others. At the same time, it traumatizes children to see the people they love most—and on whom they are most dependent—fighting and hurting each other. Children who witness violence live in constant fear of being hurt themselves because they are dependent on volatile, unpredictable adults who display violent behavior.

Estimates from a national interview sample indicate sons who witness their father's violence have a 1,000% greater rate of wife abuse than sons who do not.² Our clinical experience also indicates that a propensity toward family violence is, in part, a direct result of growing up witnessing violence in the home. Almost 90% of our clients who are victims of domestic violence were raised in households where they witnessed domestic violence; many were physically or sexually abused as children. Almost without exception,

the men in our programs for batterers (those who commit domestic violence) report being exposed to violence between their parents. The children we counsel are frightened and emotionally distressed by the violence they witness as well as the violence they experience directly as physical or sexual abuse.

While the overall problem of family violence is a societal one that must be addressed at many levels to promote change, the effects of violence are experienced individually. By assisting individual patients through outreach, support, and referral, physicians can help break the family cycles of abuse.

The experience of the child witness

As secondary victims of domestic violence, child witnesses have not received the public and professional attention that has been focused on direct victims of child abuse since the 1950s.³ Nevertheless, it is estimated that each year in the United States, 3.3 million children ages three to seventeen are at risk of exposure to violence between their parents;⁴ of these, approximately 35% directly experience victimization in some way.⁵

That so many children can in essence be "forgotten" may be attributed to the dynamics of the abusive family; an implicit rule is "keeping the secret."⁶ The silence has been aided by societal denial of the problem of domestic violence in general and reluctance to challenge the privacy of the family unit.

Children experience a myriad of traumas growing up in a violent household. They may overhear the violence; they may be exposed to threats of violence; or they may witness violent acts such as the throwing of objects randomly or at someone, pushing, slapping, spitting, kicking, hitting, beating, threats with a weapon, use of a weapon, hostage holding, and sexual assault. Such violence is often intentional and repetitive; it also includes mental abuse and intimidation as integral parts of the abuse.

Over time, child witnesses may be exposed to drug abuse and alcoholism, separations and divorce, relocations, and additional perpetrators of violence. Our experience indicates such factors significantly increase the likelihood that these children will have similar tendencies later in life. A terrifying portrait of fear and chaos emerges that affects them socially, psychologically, educationally, and physically.⁷

Characteristics of child witnesses

Feelings. Many children seen in a crisis center are victims of more than one kind of abuse. Among our clients who witness domestic violence and experience child sexual assault, the carryover between populations is as much as 70%. These children generally exhibit feelings of guilt, shame, lack of trust, poor self-esteem, helplessness, and hopelessness. They may present as high-functioning children who excel in school or sports, but they have difficulty expressing their feelings. They may deny the violence, make excuses for their parents' behav-

ior, or avoid talking about it. They also may express concern about other family members' ability to deal with the stress and violence. Two of the most difficult issues for the child witness are the ambivalence and conflict felt towards the perpetrator; the child both loves the person and hates his or her behavior.

Behavior. Domestic violence as behavior is seen many times when an older child is abusive toward a younger sibling, patterning behavior after that of perpetrators. Such children have learned poor problem solving skills and are unable to control their anger and impulses. When frustrated and challenged, they resort to violence. They seem unable to communicate feelings and thoughts in a healthy way. Their sense of personal boundaries is poor and they lack respect for others' privacy or belongings. Siblings may play out among themselves what occurs in the parental relationship.

Gender differences. Girls may be protective of the mother and identify with her. Many deny stress and trauma and/or learn a response of passivity. Boys tend to identify with the father/aggressor, bullying and/or inflicting violence on their peers or siblings. As boys enter puberty, they may express anger at the mother in the form of lost esteem because of her inability to change her situation. They may blame her as well.

Roles. Child witnesses of domestic violence often assume certain characteristic roles. Perfectionist children use all their strength to cope and to attempt to control a chaotic home environment. Scapegoated children act out in an effort to divert the parents' feuding. Clown-like children allow themselves to be patronized or laughed at to diffuse family anxiety.

Growth and development. The unpredictable, volatile home environment is extremely stressful to normal child growth and development. Some children fail to reach normal developmental landmarks or even regress (e.g., bed-wetting or soiling after having been toilet trained).

Table 1 lists behaviors according to age that may further help physicians identify domestic violence witnesses. These behaviors may continue into the next developmental stage.

Case histories

The following clinical presentations illustrate behaviors and symptoms that physicians may see in children who witness domestic violence.

Young child. Mrs. F. sought treatment for her two sons, ages four and a half and two, who had witnessed violence since birth. She said her estranged husband continued to harass her. The court had awarded joint custody of the children. Mrs. F. said the children were more violent with each other and more emotionally withdrawn from her after visiting their father. She occasionally noted bruises and cigarette burns on her sons' bodies, but neither the father nor the boys provided an explanation.

Both boys tore their teddy bears apart. The older boy's primary exhibited behavior was aggression toward his brother

Table 1. Behaviors associated with domestic violence witnesses*

| Infants | Toddlers | School-age children | Teenagers |
|---|--|---|---|
| Injury to the body | Injury to the body | Injury to the body | Injury to the body |
| Poor health | Frequent illness | Frequent illness | Loss of childhood |
| Fretful sleep pattern | Shyness, withdrawn behavior | Psychosomatic complaints | "Perfect" child or "caretaker" |
| Lethargy | Low self-esteem | Hitting, stealing, lying | Helplessness |
| Physical neglect (diaper rash, sores) | Reluctance to be touched | Nightmares | Anger at the abused parent (loss of respect) |
| Vaginal or rectal discharge (often associated with sexual abuse) | Difficulty in preschool or daycare (e.g., aggressiveness, biting, hitting, difficulty sharing) | Eating disorders | Identification with aggressor |
| Excessive crying | Poor speech development | Repetitive self abuse | Isolation (fearful of bringing friends home) |
| | Separation difficulties (clinging, yelling, hiding, shaking) | Nervous disorder (e.g., stuttering, tics) | Delinquent behavior (e.g., running away) |
| | Excessive fantasy in play | Lack of motivation | Difficulty with siblings |
| | | Poor grades | Heightened suicide risk (thoughts of doing away with self or parents) |
| | | Depression | Drug/alcohol abuse |
| | | Need to be perfect | Sexual acting out |
| | | Withdrawal | |
| | | Attention-seeking | |
| | | Sophisticated knowledge of sex | |
| | | Drug/alcohol abuse | |
| | | Regression (e.g. thumb-sucking, bed-wetting) | |
| | | Protective of mother | |
| | | Assuming parental role with younger siblings | |
| | | Difficulty with siblings (displaced anger) | |
| | | Identification with aggressor | |

* Developed by SADVC, Inc., Baltimore County

and the family dog. He was unable to stay in preschool because he bit and pinched other children. He was described as lethargic and still in need of an afternoon nap because he had frequent nightmares. The teacher said he was a "sad little boy" who showed no excitement or interest in playing with the toys or other children. He recently had begun to wet his pants during the day. His mother said he had stopped dressing himself.

The younger boy was asthmatic. He suffered from continual diaper rash following his regression to wetting. He had minimal speech and refused to communicate with anyone but his mother. He cried and had tantrums at any frustration.

During the interview and initial sessions, the children refused to separate from their mother. They were so fearful that she had to stay in the room and play with the toys with them.

Diagnostic indicators in this case were

- reported aggression;
- physical injuries;
- poor health;
- regressions;
- separation difficulties;
- poor speech development;

- lethargy; and
- tantrums.

Latency-aged child. Larry was an obese ten-year-old whose parents had been in a violent relationship since his birth. He was suspicious and hypervigilant in all new situations. He had repeated second grade and was now doing below average work in fourth grade. He also had a speech impediment. Among his few friends he was usually the target of taunts. The object of Larry's anger was his five-year-old sibling.

Larry assumed the protector role toward his mother. He wanted to be "the man in the family." Feeling it was his responsibility to shield his mother from violence, he often put himself in the middle of his parents' fights. At other times, wanting his mother to care for him, he curled up in bed with her at night.

During the course of therapy, Larry was encouraged to identify and express his feelings. This was difficult because he denied any emotions, positive or negative. He initially refused to admit his parents ever disagreed. He was adept at using mature verbalizations to defend himself against showing emotion. Drawing helped him express and talk about some of his

frightened, angry feelings. When therapy terminated, Larry was beginning to make some positive changes. He felt better about his capabilities, had lost some weight, and was involved in an organized boys group. His parents realized they also needed therapy and had joined domestic violence support groups. Larry was referred for long-term individual therapy. It was hoped that eventually Larry and his parents would be involved in family therapy.

Diagnostic indicators in this case were

- regression;
- weight problem;
- poor academic record;
- speech difficulty;
- aggression;
- poor peer relationships; and
- confused family roles.

Adolescent. Soni, a 16-year-old who excelled artistically, was the middle child of recovering alcoholics. Her father had stopped physically abusing her mother, but continued to abuse her verbally and emotionally. Soni had taken on a protector role in the family. She was disturbed by her mother's sadness and her decision to stay in the marriage. She expressed concern about her eight-year-old sibling's constant crying and inability to maintain friends.

Two years earlier, Soni had been hospitalized after attempting suicide with an overdose of antidepressants prescribed for her sleep difficulties, lack of appetite, inability to concentrate, and poor school achievement. At the time of admission, she had a black eye that she said her boyfriend had caused. During the hospitalization, she was treated for marijuana and alcohol abuse.

Soni was articulate and spoke of the family violence and chaos in a very adult manner. She took responsibility for her father's violent outbursts by saying, "If only I had put away my clothes...." When asked to talk about her feelings, however, she cried and withdrew. She did share her feelings of isolation when she reported being afraid to bring her friends home because of her father's unpredictability.

Diagnostic indicators in this case were

- suicide attempt;
- familial history of alcoholism;
- drug abuse;
- physical injury;
- isolation;
- depression;
- difficulty dealing with feelings;
- adult demeanor;
- protective role; and
- sense of assumed responsibility.

Treatment

Children. Witnesses to domestic violence can be helped by counseling that includes educational, supportive, and emo-

tional approaches. The child ideally is offered individual sessions to establish a trusting alliance with the therapist. Then the child enters into group therapy to encourage interpersonal skills development and help break through feelings of shame, isolation, and denial. Children respond well to art, play, and verbal therapies.

The goal of counseling is to help children understand that they are not responsible for the domestic violence and chaos at home, that they cannot change it, and that they cannot control it. Children are informed that the first and foremost concern must be for their safety and that of their siblings. They are taught to identify feelings and to express them in a healthy manner. They are taught to deal with intense feelings of anger by using coping mechanisms such as punching a pillow, going out for a run, or talking it out. Therapists also work on building the child's self-esteem and sense of personal worth.

Parents. Parents willing to participate in counseling are taught alternative, nonviolent methods of discipline and communication. They learn to modify their behavior and establish logical consequences—rather than emotional or physical responses—to negative behaviors. They learn to give their children rules and limits so that there is a sense of control and order in their lives, which otherwise are disordered and unstructured. Parents also are encouraged to attend parenting classes and affiliate with groups such as Parents Anonymous for additional support with their children.

The role of the physician

Because domestic violence is associated with shame and secrecy, it is often difficult to convince victims (abused parents, usually the mother) to make changes for themselves. They may be motivated, however, when they are made aware that staying in an abusive situation is detrimental to the physical and emotional well-being of the children. Before a child's behavior can improve, the child must be in a safe environment. Parents more readily accept referrals to shelters, support and counseling agencies, police, and the legal system when approached in this manner.

In Maryland, physicians are required by law to report suspected cases of child abuse or neglect to the local department of social services or the police. They can refer a suspected adult victim of domestic violence to the police, local domestic violence program, or an emergency room as appropriate. Physicians can broach the subject of domestic violence and let victims know that, as informed doctors, they are a resource for both the victim and the children. It is vital that physicians approach such patients in a supportive and reassuring manner to avoid making them feel they are being judged negatively as a parent, which only increases shame and secrecy.

As the medical community becomes more aware of this problem in our society—a problem that persists generation after generation—we can try to meet the needs of battered

parents and child witnesses. In doing so, we may be able to help end the cyclic problem of domestic violence.

References

1. Gelles RJ, Conte, JR. Domestic violence and sexual abuse of children: A review of research in the eighties. *Journal of Marriage and the Family*. 1990; 52:1045-58.
2. Straus MA, Gelles RJ, Steinmetz SK. *Behind Closed Doors: Violence in the American Family*. Garden City, NY: Anchor. 1980.
3. Peled E, Davis D. *Groupwork with Child Witnesses of Domestic Violence: A Practitioner's Manual*. Minneapolis: The Domestic Abuse Project. 1992; 1-13.
4. Carlson BE. Children's observations of interparental violence. In: Roberts AR (ed). *Battered Women and Their Families*. New York: Springer. 1984; 147-67.
5. Davis D. *Working with Children From Violent Homes*. Santa Cruz, California: Network Publications. 1986.
6. Gruszek RJ, Brink JC, Edelson JL. Support and education groups for children of battered women. *Child Welfare* 1988; 67:435.
7. Jaffe PG, Wolfe DA, Wilson, KA. *Children of Battered Women*. Newbury Park, California: Sage. 1990; 31.

The Sexual Assault and Domestic Violence Center, Inc., is a private, nonprofit, comprehensive treatment center for victims of sexual assault and domestic violence in Baltimore County. The office number is (410) 377-8111. The 24-hour hotline is (410) 828-6390. The location and phone numbers of other county programs throughout the State of Maryland can be obtained through the Maryland Network Against Domestic Violence, 1-800-MD-HELPS. ■



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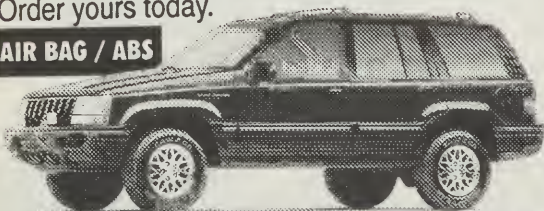
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The use of art therapy in family violence

Eena R. Bass-Feld, M.A., A.T.R., C.P.C.

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Art therapy is a relatively new, nonverbal discipline with its roots in psychodynamic theory. It dates back to the early work of Margaret Naumberg in the 1940s and Edith Kramer in the 1950s. Naumberg's approach was aimed at releasing the unconscious through spontaneous art expression. Kramer saw the primary function of the art therapist as assisting with sublimation. Both pioneers based their work in Freudian ego psychology.

Art therapy provides another language for expression of thoughts and feelings. It uses the creative artistic process to facilitate catharsis, reconcile emotional conflicts, increase insights, and promote personal change and growth. The art is a projection of unconscious material that escapes censorship, as well as a reflection of the individual's personality. Art therapy recognizes both the process and the product. It is necessary to listen to the client's verbal associations to the artwork.

Art therapy can be used for diagnosis or treatment. As a therapeutic intervention, it is used in psychiatric centers, outpatient facilities, residential centers, schools, penal or correctional institutions, and drug and alcohol treatment centers. It is useful with children, adolescents, and adults; it can be used individually, in groups, or in family sessions. Depending on the setting, art therapists can be primary therapists or adjunctive therapists.

For victims of family violence, whose basic trust has been violated, use of art in the therapeutic setting offers a means of communication less threatening than verbalization. It provides a safe alternative for communicating emotions surrounding the violence and trauma. Victims can use it to externalize and work through repressed feelings. The art itself is healing. It helps victims deal with the pain, guilt, anger, ambivalence, and secrecy of the incident experienced. It is also a means of building the self-esteem and confidence that victims of family violence lack.

The following pictures were drawn by children and adolescents who witnessed family violence or were abused. The children who drew these pictures authorized their use to educate the public and help others understand the impact of violence in their lives.



Art task: Spontaneous drawing.

The artist is the small, helpless-looking figure on the left with no hands. The perpetrator is drawn as a nonhuman robot. Note the aggression in the stances, the club-like hands with sharp nails, and the teeth.

Drawn by a 7-year-old male witness to domestic violence.



**Art task: Draw a picture
of the perpetrator of
domestic violence.**

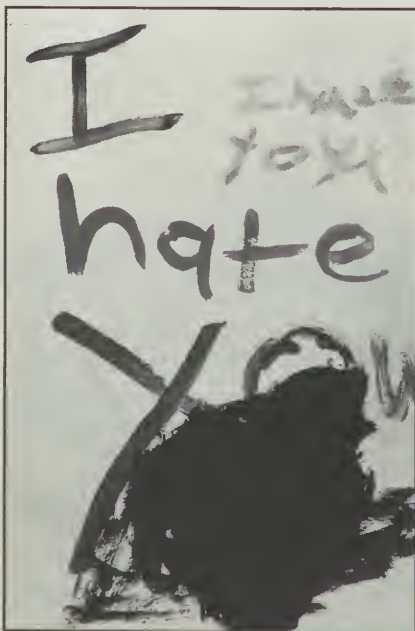
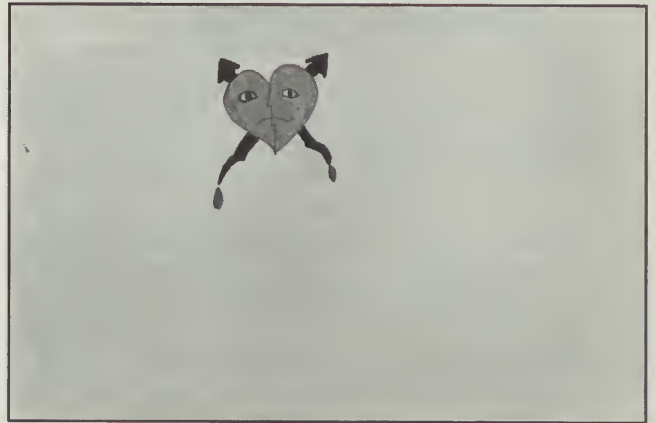
Note the aggressive stance and weapons on the figure. The artist also chose to use red for the figure's outline and black for the figure's left arm, right hand and armor.

*Drawn by a 6-year-old male
witness to domestic violence.*

**Art task: Spontaneous
drawing.**

The child was the victim of acquaintance rape; the perpetrator was exonerated in court. The drawing—entitled “Love/Hurt”—was done after a discussion of feelings.

*Drawn by a 14-year-old female
witness to domestic violence who
was in a teenage group for sexual
abuse/assault issues.*



**Art task: Draw a picture
of the person who abused
you.**

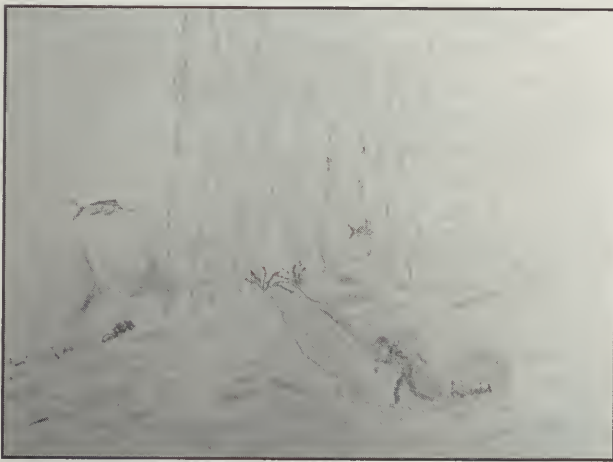
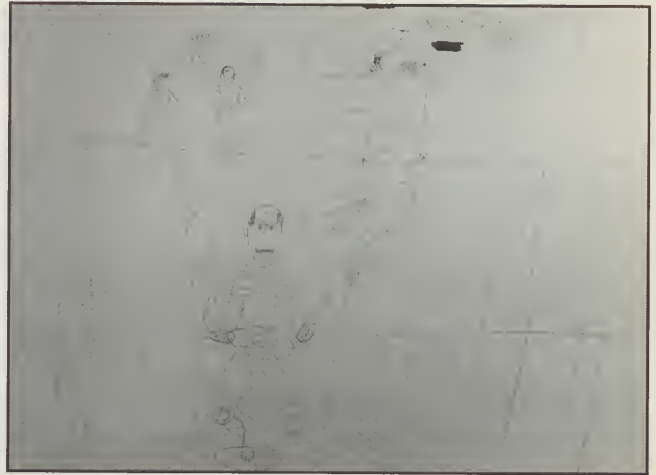
The child drew the figure and became overwhelmed by the image. She covered it over with black paint and then wrote over it.

*Drawn by a 7-year-old female victim
of child abuse and witness to
domestic violence.*

Art task: What would you like to happen to the perpetrator?

The child and mother are on top of jail gaining great pleasure from the perpetrator's imprisonment. The child is still fearful of the perpetrator's power as evidenced by the written threat from the perpetrator.

Drawn by a 12-year-old male witness to domestic violence.



Art task: First spontaneous drawing.

The theme suggests the child's sense of impending danger: note the sharks, swordfish, and skeleton. The figure is hidden in a safe place complete with oxygen for survival.

Drawn by a 12-year-old male witness to domestic violence.

Art task: Draw a picture of your family doing something together.

Note the floating figures at the crossroads, suggesting lack of direction and stability. Use of isolated color on the family members and tree suggests extreme control over emotions.

Drawn by a 12-year-old male witness to domestic violence.



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The aftereffects of witnessing family violence

*When i was young and not so smart
There were many things that broke my heart*

*I needed nuturing love and care
It was a shame no one was ever there*

*The disfunction of my mom and dad
Made my life completly sad*

*My mom was abused as a child i'm sure
Much pain and suffering she did endure*

*The anger she felt from her childhood days
Would manafest itself in fits of rage*

*That left her with only one thing to do
Continue the abuse that's all she knew*

*I knew not much of my fathers life
His father worked hard he had a good wife*

*He started drinking just to have fun
The alcohol consumed him he tried to run*

*He ran from lifes trouble and pain
Only to come back home drunk again*

*My fathers drinking my mothers rage
Was all that was needed to set the stage*

*For a life that's full of violence and hate
What could they do it was their fate*

*I survived those childhood years intact
And now i know that i must act*

*To use the knowledge i have gained
To change my life to end the pain*



*When i left my mothers womb
I felt as though i had left a tomb*

*What was this crying that i felt
what kind of hand had i been delt*

*While in the nursery where i lay
I listened to the other children i heard them play*

*I want my dad I heard them shout
what is this dad stuff all about*

*They took me to my mothers bed
she laid me there and propped my head*

*A bottle in my mouth was placed
It feels so hard i hate the taste*

*The nurse came in i heard her say
Where is the proud dad today*

*I saw a tear in mothers eye
what is this dad that makes her cry*

*One day i hope to find out why
this thing called 'dad' makes everyone cry*

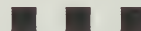


THE AUTHOR OF THE FOLLOWING POETRY grew up in an extremely violent household. A Vietnam veteran, he remarks, "Being in Vietnam was not as bad as living in that household as a child.... At least in Nam I felt I had some choice about being there."

As a young child he tried, often without success, to prevent or referee his parents' bloody fights. He tried to take care of his four younger siblings and the household and to earn money for food and clothes. He was too ashamed of his home situation to risk having friends. The lesson he learned was that it was unsafe to be vulnerable or share feelings with those closest to him—his parents. Never able to trust his parents to love or care for him in an appropriate or consistent way, he unknowingly blocked his emotions to ensure his survival.

The painful effects of having witnessed domestic violence continue into his adulthood. Although he is a successful executive in his field, it remains difficult and frightening for him to experience his emotions. Slowly unblocking the sadness, fear, and pain of his formative years, he struggles to achieve intimacy in his marriage and show love to his children. He has just begun to make friends for the first time in his life. As he states today, "It is very sad to go for 45 to 50 years not knowing who you are and having so many unanswered questions."

Dorothy J. Thormaehlen, L.C.S.W.-C.



*From the moment of conception
I knew my life was an exception*

*From the normal life that children live
I had a father that couldn't give*

*The love the time and the guiding light
That allows a childs life to be full and bright*

*For a child you see has special needs
That only a father can give through his deeds*

*When a fathers deeds are cold and harsh
A child feels as though he's in a marsh*

*The marsh holds him fast so he cannot grow
As children do with that special glow*

*They glow when things are going right
They have no fear their futures bright*

*The darkness comes when dad's not there
They know too well he does not care*

*When these feelings go on for years
A child reacts he hides his tears*

*He cannot allow the world to know
The hurt inside it must not show*

*He keeps it hid the best he can
He awakes one day he is a man*

*His life is empty and full of doubt
he tries and tries to figure it out*

*It came into his mind one day
That his childhood was taken away*

*It seems so tragic and so sad
To think of the childhood i never had*

*When i came into this world i was a perfect
child*

*The natural things i needed then were
considered out of style*

*To think that glass and rubber can replace the
natural need*

*Is as far from the mothers role as want is from
need*

*For natural things a child does need
why cant our parents just take heed*

*I turned into a man one day
my little child he went away*

*And in time as most men do
realized my life was all askew*

*I tried and tried to reach a conclusion
why my life was full of confusion*

*The nurturing deprived me as a child
had made my life completely wild*

*I found my child where i left him
crying for love and attention*

*He never left me i found out
it's what my pain is all about*

*He needs my love he needs my care
he needs to know that i'll be there*

*My inner child hopes some day
just to be able to go out and play*

Physicians and attorneys: a partnership on behalf of the youngest victims of family violence

Julie A. Drake, Esq.

Ms. Drake is assistant state's attorney, Baltimore City Child Abuse Unit.

ABSTRACT: *Physicians play a vital role in court proceedings involving child abuse. This article describes the legal obligation of Maryland health care providers to report suspected cases of child abuse. It also discusses various types of testimony that may be required; reasons why physicians may be reluctant to testify; and why some types of testimony may be disallowed.*

Case history

On September 12, 1993, a three-month-old infant was brought to Mercy Medical Center for treatment. Upon arrival, Baby Guy appeared lifeless. He was unconscious and unresponsive to pain stimuli. His mother said he had "gone downhill" following a diphtheria/pertussis/tetanus (DTP) shot. Baby Guy was rushed to the University of Maryland pediatric intensive care unit, where radiology reports indicated he had been battered repeatedly over the preceding six weeks.

There were no eyewitnesses to the crime, but both parents subsequently were charged with child abuse. They denied observing any signs of serious illness and insisted the injuries occurred as the result of a fall. At their trial, the chief of the pediatric radiology unit at University of Maryland Hospital testified that the child had been battered on at least three separate occasions, resulting in injuries that included five fractured ribs; fractured femurs; numerous broken bones in the hands and foot; a fractured skull; hemorrhaging behind the eyes; and massive intracranial pressure leading to virtual destruction of the cerebral cortex and cerebellum. The director of the pediatric ambulatory care center at Mercy testified that each of the injuries occurred as the result of an act of abuse; under intense cross-examination, he refused to concede that even one of the injuries could have occurred accidentally. Both physicians testified that the child sustained serious, permanent brain damage and is blind.

Convictions were obtained in this case largely through the testimony of the two medical experts. The father was sentenced to 43 years in the

Department of Corrections. The mother was placed on probation with the condition that she participate in psychotherapy and comply with the requirements of the Alternative Sentencing Unit.

Testimony from medical experts frequently is essential to successful child abuse prosecution. Good communication and a collaborative approach are critical if physicians and attorneys are to work together to ensure that children are protected. The first step in the process is education. Physicians regularly share pertinent medical data with attorneys who specialize in cases involving child abuse. Conversely, it is helpful if physicians involved in the diagnosis and treatment of abused children have a basic understanding of the legal process surrounding this type of case.

Reporting child abuse

An investigation of suspected child abuse is initiated by a report to either the police or to the Department of Social Services. Under Maryland law,¹ physicians and other health care providers are required to make a report whenever there is reason to believe that child abuse may have occurred. It is important to note that the physician need not have observed an injury or even have spoken to the victim. A disclosure by either the abuser or the victim is sufficient to trigger the obligation to report.

Physicians may be reluctant to make such reports for a variety of reasons. No physician wishes to violate a patient's right to confidentiality or jeopardize the relationship between doctor and patient. These considerations are particularly compelling if the patient requests confidentiality while making a disclosure for the purpose of obtaining treatment. Notwithstanding the doctor's sympathy or inclination, there is no exception in Maryland law to justify a failure to report suspected abuse promptly; to do so leaves other children at risk.

Physicians occasionally question the degree of evidence required to justify a report. For example, the physician may be faced with a suspicious injury that does not constitute unequivocal evidence of child abuse. However, the physician need not be convinced that abuse has occurred. The obligation to report is triggered by reasonable suspicion; determining whether abuse has actually occurred is the responsibility of the investigative agencies.

Once a report is generated, dual investigations are conducted by the Department of Social Services and the police department. If the report is substantiated and the police file charges, the physician may be summoned to appear in two distinct legal proceedings.

Court proceedings

Juvenile court. Physicians frequently are asked to appear in juvenile court for Child in Need of Assistance (CINA) proceedings. The purpose of the CINA adjudication is to determine

whether a child has been abused or neglected so that appropriate placement and treatment can be implemented. There are no juries in juvenile court. All hearings are conducted before a judge or master whose primary responsibility is to determine the best interests of the child. If the parents fail to comply with the treatment plan, the sanction may involve long-term removal of the child.

Criminal court. A criminal trial typically is conducted before a jury, and the abuser is entitled to all the constitutional protections afforded a criminal defendant. The criminal trial includes a higher standard of proof; the prosecutor must prove every element of the crime beyond a reasonable doubt. At disposition, the primary focus is the defendant, who may be required to participate in a treatment program as a condition of probation. Defendants who are inappropriate candidates for probation may be imprisoned.

Reluctance to testify. Attorneys who specialize in child abuse cases have noted the difficulty with which some doctors are coaxed into court. Indeed, physicians express a number of reservations regarding participation in child abuse prosecutions. The most common objection to testifying is lack of time. The typical physician is responsible for a staggering caseload and cannot walk away from patients to wait outside a courtroom. The problem is exacerbated by last-minute postponements, which can frustrate conscientious physicians who clear their schedules to be available for a court appearance. Defense attorneys are well aware of the effect of repeated postponements. (The case of Baby Guy was postponed at the defendants' request no less than three times, all within one day of the trial date.) At the start of a trial, however, busy physicians may be excused from appearing in court with other witnesses. They can be placed "on call" and, with the Court's help, the timing of their testimony can be coordinated with their other important obligations.

A related concern is the belief that, because the attorneys have access to the medical records, medical testimony is not really necessary to achieve the objectives of the court proceeding. Although stipulations to medical findings are common in juvenile court, it is unusual for a defense attorney in a criminal trial to forego the opportunity to exercise the defendant's constitutional right to cross-examination. Moreover, many judges, attorneys, and jurors have difficulty deciphering significant notations in medical records. In most cases, the value of the physician's testimony far surpasses the bare medical facts outlined in the records. In addition, there is one important function performed by the medical witness that cannot be accomplished with even the most legible medical record. While most witnesses may only testify regarding their direct observations, the physician may be qualified as a medical expert and thus may testify regarding his or her opinion as to the cause of the child's injury. Such testimony may be critical in cases where the defendant claims the child's injury was self-

inflicted or due to an accident. Only an expert witness can offer an opinion as to the cause of an injury and translate technical medical language into a clear picture that attorneys and jurors can comprehend.

Reluctance to testify also may be related to a general discomfort with the legal arena. Physicians may fear the prospect of being attacked by an aggressive or unscrupulous attorney during cross-examination. Indeed, the mere notion of answering questions before a courtroom full of spectators can be unnerving. In most cases, however, the prosecutor will meet with the physician before the court proceeding to review testimony, explain court procedure, and answer questions. Comfort under cross-examination is largely a function of experience and preparation. A good attorney will be happy to assist the physician in preparing for trial.

Occasionally a physician's reluctance to participate in a criminal proceeding stems from misgivings about the "punitive" nature of prosecution or sympathy for the defendant. It is true that a small percentage of child abusers constitute a threat to public safety and must be incarcerated. The majority of prosecutions, however, result in implementation of a treatment plan that may include individual or family counseling, substance abuse treatment, parenting classes, or participation in a support group such as Parents Anonymous. Prosecutions that result in imprisonment typically involve serious injuries and/or a defendant with a lengthy criminal record. It is also important to keep in mind that emotional problems that generate violent, abusive behavior rarely disappear without motivation and treatment. The children trapped in violent homes bear witness to this violence by acting it out in other settings and by repeating it as adults. Court intervention helps break the cycle of violence. The physician can play an essential role by clarifying the nature of the injury so that the focus of all parties can shift to appropriate intervention.

Hearsay evidence. While some doctors experience misgivings regarding court participation, others are outraged to discover that prosecutors are not pursuing cases involving serious physical or sexual child abuse. This is particularly upsetting when the physician has reported an egregious case and is eager to testify on the child's behalf. The most common reason for the state's failure to pursue prosecution of a serious case is the severe limitation placed on the admission of hearsay evidence.

Under Maryland law, a physician may not testify regarding any disclosures made by a child abuse victim unless the disclosure is admissible under a recognized exception to the rule prohibiting hearsay evidence. One exception allows a physician to testify regarding disclosures made by a patient when the disclosures are relevant to diagnosis or treatment ("pathologically germane"). Thus, the physician may testify regarding the victim's statements about the means by which injury was inflicted, but not about the victim's identification of

the perpetrator. In *Cassidy v. State*, Maryland's Court of Special Appeals ruled that the identity of the perpetrator normally is not "pathologically germane" and therefore is inadmissible.² Since the prosecutor must prove the identity of the abuser beyond a reasonable doubt, the effect of *Cassidy* has been to limit prosecutions.

The legislative response to this problem was enactment in 1987 of a statute that permits a licensed physician (or a licensed psychologist or social worker or a teacher) to testify regarding disclosures made by a child abuse victim under age 12, including identification of the abuser.³ The statute, however, contains a significant limitation. The physician may not testify regarding the child's statements unless the child testifies first or is ruled unable to testify for one of four (highly unusual) reasons. In most cases, the victim is unable to testify for a reason not addressed by the statute; in most cases, the victim is old enough to describe the abuse to a doctor, but too young to qualify as a competent trial witness. In these cases, both the child and the doctor are precluded from testifying about the victim's disclosures.

These cases are galling to both the physician and the prosecutor. The statute clearly leaves our youngest and most vulnerable children at risk and rewards perpetrators for selecting victims too young to testify regarding their abuse. Efforts are currently underway to amend the statute to permit introduction of hearsay testimony in cases where the hearsay is reliable, but the child is not capable of testifying. The outcome of these efforts is uncertain.

As the case of Baby Guy illustrates, physicians traditionally have played an essential role in the identification and prosecution of child abuse. Despite differing agendas, physicians and prosecutors have formed an enduring partnership on behalf of young victims of family violence. That partnership recently has expanded beyond the courtroom to include alliances designed to address the root causes of abuse. It is hoped that members of the legal and medical communities will now build on their partnership by advocating for systemic changes to benefit the youngest and most vulnerable victims of family violence.

References

1. Annotated Code of Maryland, Family Law Article, Section 5-704. 1991 Replacement Volume.
2. *Cassidy v. State*, 74 Md. App. 1, 536 A.2d 666 (1988).
3. Annotated Code of Maryland, Courts and Judicial Proceedings, Section 9-103.1. 1989 Replacement Volume. ■

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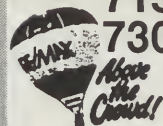
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Book Reviews

Severe Burns. A Family Guide to Medical and Emotional Recovery. Andrew M. Munster, M.D. and the staff of the Baltimore Regional Burn Center. The Johns Hopkins University Press. 1993. 246 pages. \$25.95.

All surgery textbooks contain a section about the treating burns. Munster and his colleagues have made a quantum leap forward, however, because they have written a book about the medical and emotional needs of patients with burns. This book is designed to give patients and their family members knowledge that will help them cope with the initial bodily injury, and the long period of recovery, physical reconstruction, and mental adjustment associated with the treatment of severe burns. The problem is staggering. Each year in the United States, an estimated 20,000 individuals die and an additional 75,000-100,000 individuals are hospitalized because of fire-related injuries.

The author/editor is well-qualified; he is the director of the Baltimore Regional Burn Center which treats approximately 300 severely burned patients a year. Dr. Munster makes a sound presentation about the numerous facets of treating severely burned patients.

In the past, extensive third-degree burns often have been considered hopeless conditions by burn victims and their relatives. However, advances in treatment and acquired experience in treating severe burns have led recently to more optimistic expectations. Although little can be done to reverse the initial destruction, during the past several decades, methods that limit tissue loss, progressive functional difficulties due to contractures, the disabling effects of burns upon the minds of the patients and their relatives, and death have been designed. Some burns, beset with complications, still require long periods of treatment, however, sound therapeutic principles continue to produce better results.

The book discusses critical care, the role of crisis intervention counselors, the medical aspects of care, physical rehabilitation, reconstructive surgery, the use of organized support services during the long



Andrew M. Munster, M.D.

period of recovery, and the prevention of fires. The information is written for readers without a medical background.

Not surprisingly, a detailed discussion of fire prevention is a distinctive feature of this book. Eighty-five percent of burn injuries occur in the home, therefore, parents, children, and visitors should be thoroughly familiar with installed safeguards against fires and know how to take evasive action if a fire occurs.

The appendices are devoted to first aid, corrective cosmetics, and a list of burn care services in the United States and Canada. The list of sites offering specialized therapy for burn victims provides physicians with resources for patient referrals. A glossary and an index explain the medical terms used in the book.

Fundamentally, this book was not written for practicing physicians, although physicians may gain some valuable information by reading it. Rather, the book is directed toward burn victims and their relatives. In a larger sense, it also is directed to the public because it offers fire prevention advice. The book should be in all public libraries.

JOSEPH M. MILLER, M.D.
Timonium, Maryland



Health Care Reform as Social Change.

Richard E. Thompson, M.D. The American College of Physician Executives. 1993. 179 pages. \$34.00

Since *MMJ* readers might not get to the "bottom line" of this review, its "top line" is **some physicians may find this book interesting and entertaining.**

The book's title is somewhat misleading, since more space is devoted to descriptions of the health sector and changes that have occurred in the practice of medicine, than to current proposals for medical care reform. The subjects covered include twenty years of symptomatic treatment; flawed federal policies; pumped up public expectations; values of people in business; lack of leadership; lawyers and consultants; unpublicized cost factors; reactions....to disappointed expectations; collaborative effort; and the quality issue. The book devotes only one chapter to proposed cures and chances for success. It closes with an appendix on action ideas and self-help suggestions that I did not find to be particularly helpful. For example, the author says the successful health care executive "displays a positive professional attitude." Such clichés don't provide any substantive information and are not really helpful.

A number of mostly amusing cartoons and pithy quotes enliven the book, for example,

- If we do not change our direction, we are very likely to end up exactly where we are headed.
- Would you prefer to be 'marketed' or 'cared' for?
- Would you prefer to have...medical services...or would you like to be considered as a 'product line'?
- He doesn't seem to know what's right, only what's legal.

The book also contains an interesting section on the Joint Committee on Accreditation of Health Care Organizations, of which the author is a member. An extensive list of references that vary in

quality from Uwe Reinhardt, Bob Blendon, and Eli Ginzberg articles in the *New England Journal of Medicine* and *JAMA* to stories carried in *Time Magazine* and the *St. Petersburg Times* is included. Generally, the references are quite helpful.

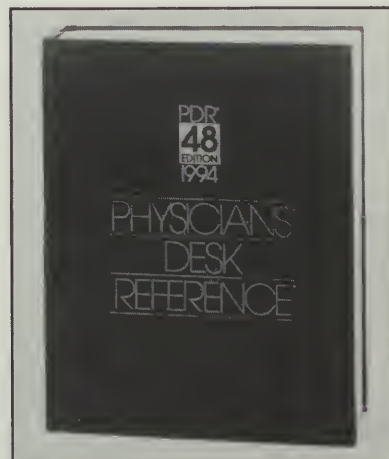
In summary, my own bottom line for this review is that I enjoyed reading this book. However, I will not keep my review copy as a reference, but will turn it over to the Med Chi Library where other *MMJ* readers might find it.

TIMOTHY D. BAKER, M.D., M.P.H.
Baltimore, Maryland



1994 Physician's Desk Reference.®
Medical Economics Data. 1994. 2,670 pages. \$59.95.

My *1994 Physician's Desk Reference*® (*PDR*®) hasn't arrived yet, and I'm getting uneasy. I do have a copy that has been loaned to me—it's red this year and quite heavy, as books go. But, it's not "my" *PDR*.® I've always received my *PDR*® as a gift, and, therefore, have taken it for granted, perhaps even abused it. I've watched old copies of the *PDR*® languish, along with condensed books and outdated consumer reports, on the tables at college used book sales.



The first *PDR*® arrived in 1947. The volume grew from 380 pages to 632 pages by 1966. Pill pictures were added in 1961. The current edition has 2,669 pages of small print and thin paper—about the limit that I can pick up with one hand (without grunting).

The new edition, #48, resembles the older editions, and includes many useful features. I especially liked the introductory tables and pictures. The Product Name Index now lists generic drugs next to original brand name drugs. For example, Tegretol is listed under Carbamazepine along with four other products from different manufacturers. Tegretol also is listed separately among the T's, but other carbamazepines are not. Original brand name products get preferential billing, which seems fair enough with the improved format. The other sections in the front of the book are much the same as they were in previous editions, however, a few items have been pushed to the end of the book. The type and the layout in a few areas such as the Table of Contents have been improved, and are easier to read.

Maybe I said something to a drug representative. I suppose someone might have mistook my good-natured cynicism for an anticorporate statement. I must have been politically incorrect and must now suffer with my old PDR.®

The book is crammed with data and therein lies a problem—what to do with the information? Soon it will require an awkward amount of pages.

For those who are comfortable with video screens, the entire *PDR*® is available on CD-ROM for \$595. The *Pocket PDR*® is a hand-held electronic book system for \$130. Five other data cards, including *Harrison's Internal Medicine* and the *Medical Letter Handbook of Adverse Drug Interactions*, can be read by the same gizmo. These electronic books cost \$100 apiece. With the *Pocket PDR*® and four lithium batteries, you can tote a load of knowledge in your pocket, rather than in your head.

Medical Economics Data also publishes reference books for non-prescription drugs, for ophthalmic drugs, and for drug interactions/side effects.

Perhaps word got back to the publisher in Montvale, New Jersey that I encouraged patients to complain about medications that cost over \$2.00 per dose. Or maybe it's because I wrote all those prescriptions for generic drugs in 1993. Do they only send freebies to docs who always insist on brand names? After all, I did fill out the questionnaire, faithfully disclosing every detail of my life to the list makers. That should be worth something.

While I do not wish to offend the PDR® publisher, and risk having my name for-

ever banned from the mailing list, I would offer the following suggestions.

- Face up to the glut of data, limit the information in the PDR®, and offer more complete data on the limited number of medications that are commonly used by physicians.
- Make the print larger. The PDR® has become a presbyopia test for forty-year-old physicians.
- Make each entry uniform.
- Consider adding some style to the prose. Of course, it is just technical data, but one can picture a pharmacologist modifying the entries at a word processor with a marketing representative on one side and an attorney on the other side.

Some front-line practitioners would make good editors.

- Why not bite the bullet and mention something about prices? The approximate cost of a week's therapy for a given drug might seem offensive to some, but it's time for all of us in this health care swamp to start communicating clearly.

Despite its shortcomings, the PDR® is simply indispensable to most physicians. It remains a wonderful reference work. Imagine a year without it.

JOHN W. BUCKLEY, M.D.
Towson, Maryland ■

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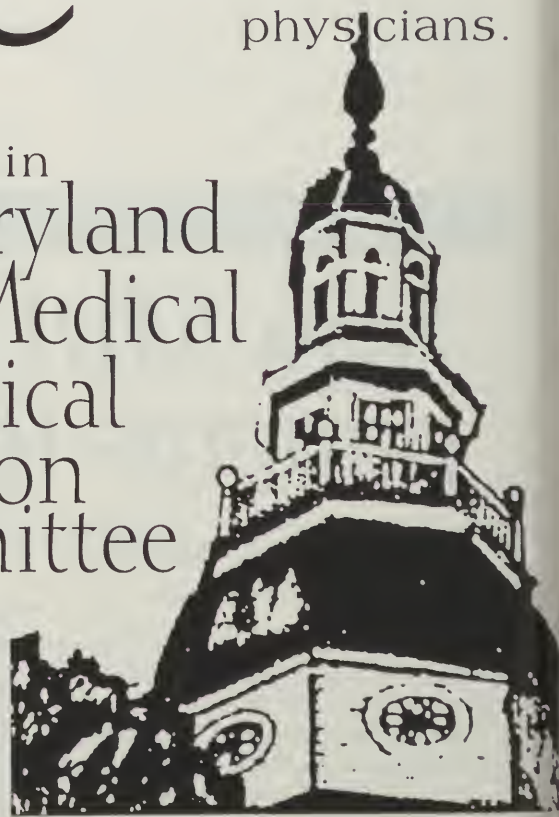
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Auxiliary

1993-94 auxiliary component presidents

ALLEGANY COUNTY



Anita S. Bauer

Allegany County is very fortunate to have Anita serve again as auxiliary president. Anita has been with this auxiliary since it began, and is serving her third term as its president.

In addition to her auxiliary duties, Anita volunteers at Memorial Hospital in Cumberland, and is a member of the hospital's auxiliary board.

Anita and her late husband, Arthur, have four sons and two grandson.

ANNE ARUNDEL COUNTY

Laura G. Riebman

During her term, Laura planned to have the auxiliary host a fashion show. The proceeds from this event benefit the auxiliary's "The Empty Nest" program, which supplies clothes to mothers who are returning to work.

During the past year, the auxiliary also began a mini internship program to educate legislators, insurance personnel, and other people who impact the medical community about medical practices. People who participated in the internships were invited to spend a day in a physician's office or a hospital.

Laura is married to Michael, a family practitioner and Med Chi member. They have two girls. Laura also volunteers in her children's school.

BALTIMORE COUNTY



Sharon M. Buckley

Sharon's main goal during her presidency was to increase membership and help revitalize the auxiliary.

Sharon's husband, John, is a psychiatrist and a past president of the Baltimore County Medical Association. Sharon manages her husband's office. They have four children.

CHARLES COUNTY

Karen Baig

Karen planned to have the auxiliary recruit new members during her term. The auxiliary also planned a fund raiser for the Physician's Memorial Hospital.

Karen and her husband, Khadar, have a three-year-old son who keeps Karen quite busy. However, Karen still finds time for tennis and reading. Dr. Baig practices internal medicine and gastroenterology.

FREDERICK COUNTY



Barbara P. Foris

Barbara is very enthusiastic about the auxiliary and describes its members as an exciting and fun group of people. This year the auxiliary held its third annual square dance and its second annual Holiday House Tour. Proceeds from the Holiday House Tour are used to benefit Hartley House for battered women.

Barbara's husband, Nicholas, is a thoracic cardiovascular surgeon. They have three children.

A retired nurse anesthetist, Barbara also keeps busy with the hospital auxiliary and her children's activities.

MONTGOMERY COUNTY



Hanna Lee Pomerantz

options for battered women.

In addition to her duties as president, Hanna Lee takes ballet lessons. She used to dance professionally with the Washington Ballet.

Hanna Lee is married to Ronald, a radiologist. They have four children, three with careers in medicine. One daughter, however, takes after her mother, and dances professionally.

During Hanna Lee's term, the auxiliary has been working with the Medical Society of the District of Columbia and the Montgomery County Agency for Victims' Services on family violence issues. The auxiliary also is trying to get a grant that will be used to produce a Spanish-language video on the legal

The other counties have retained their previous presidents to serve another term. Harford County's president is Socorro Lindado; Howard County's president is Missy Leffler; Kent County's president is Liz Donovan and Washington County's president is Gail Metzner.



Gail Metzner

Adriana Zarbin has a dual role. She is serving as auxiliary president in Baltimore City and president-elect of the Auxiliary to the Medical and Chirurgical Faculty of Maryland.



Adriana Zarbin

PRINCE GEORGE'S COUNTY

Tania Mufarrij

This year, Tania planned to have the auxiliary focus on legislative issues and hold fund raisers to benefit medical education scholarships.

Tania's husband, Imad, is a delegate for the Prince George's County Medical Society. Imad and Tania have two sons, ages three and twelve.

CLAIRE JENSEN
Baltimore City ■

WICOMICO COUNTY



Mickey Roe

Mickey and the Wicomico County Auxiliary have had a busy year. Auxiliary members have volunteered at the health department and organized "Organ Annie" and AIDS presentations at schools. Mickey also has worked to increase membership in the auxiliary.

Mickey and her husband, David, have three children. Dr. Roe's specialty is orthopedics.

MARYLAND

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STRAIGHT Forward

INFORMATION

The editorial consultants currently seek articles on the following topics:

- substance abuse issues specific to anesthesiologists,
- stress inherent in transitions in medical practice, for example, in opening a practice, in changing specialty, in preparing for retirement.

FOR AUTHORS

Straight Forward, a quarterly publication by the Physician Rehabilitation Committee of the Medical and Chirurgical Faculty of Maryland, informs Maryland physicians and other health care providers of developments in the areas of substance abuse, mental health, impairment, and recovery.

To accomplish this goal, the editorial consultants seek original informative or philosophical manuscripts on addiction, recovery, practice/patient management, and mental health. Calls for manuscripts on specific subjects will appear in future *Straight Forward* issues.

REQUIREMENTS FOR ARTICLES

1. Maximum length 2,500 words (about 10 double-spaced typed pages)
2. For references to other works within an article, cite the following information:
 - a. author(s),
 - b. complete title of work cited,
 - c. title of journal, publication, and publisher,
 - d. year of publication,
 - e. volume number,
 - f. first and last page number.
3. Submit two copies of the article, typed, double-spaced, with numbered pages and principal author's name on each page.
4. If possible, accompany the hard copies with an IBM-compatible WordPerfect disk (3 1/2" or 5 1/4").
5. A transmittal letter must accompany each submission and must contain the following elements:
 - a. the signature, full name, degree, title, and affiliation of the author(s);
 - b. a statement that the author(s) participated in forming the concept and drafting the article and take responsibility for its content and accuracy;
 - c. a statement granting *Straight Forward* copyright if the article is accepted for publication.

For a copy of a transmittal letter to which you can add information specific to your article, call 410-962-5580 or 1-800-992-7010.

Send submissions to *Straight Forward*
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Baltimore, MD 21201

The managing editor will acknowledge receiving your submission immediately, and will notify you of its status for publication as quickly as possible, generally within a month. Thank you for your interest in *Straight Forward*.

COMING OUT OF THE DARK

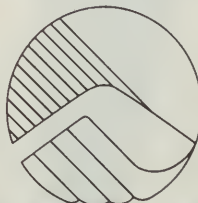
Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families.

The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201
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**Physician
Rehabilitation
Committee**

*Minutes of the Carrier Advisory Committee (CAC) Meeting
March 16, 1994*

The meeting was co-chaired by:

Joseph Berkow, M.D.

Barry Gold, M.D., Medical Director

In attendance from the Medicare Contractor were the following:

Liz Krakowski, R.N., Medical Policy Specialist

Sharon Sheppard, Medical Policy

Dorothy Callahan, R.N., Focused Medical Review

Madge Greely, R.N., Fraud & Abuse

Edith Sunderland, Professional Relations

Pat Boardley, Professional Relations

Russ Bradley, Manager, Medicare B

Helene Shugart, Director, Medicare Carrier Operations

Steve Reese, Director, Medicare Systems

Donna Novak, Manager, EMC Marketing

Jean Kreigh, EMC Marketing

In attendance from the Health Care Financing Administration (HCFA) was the following:

Sue Ambruch, R.N.

▼ **Welcome/Introduction**

The meeting was brought to order at approximately 6:30 p.m. Opening remarks were made by Dr. Berkow. Dr. Berkow commented on the poor attendance at the CAC meetings and stressed the importance of having specialty group representation by either the official representative or the alternate.

Dr. Gold reiterated the purpose of the CAC and reminded representatives that they have the ability to bring national issues to the attention of the floor and that when necessary a letter would be forwarded to the regional office at the request of the co-chair addressing specific issues.

▼ **Electronic Media Claims (EMC)**

There was a presentation on electronic media claims (EMC) given by Steve Reese, Director of Medicare Systems. During Mr. Reese's presentation, he described the different types of EMC submission, giving an overview of the cycle of the EMC process, from the initial editing of the claim data to the acknowledgment of the receipt or the rejection of the claim. Mr. Reese gave background on the EMC marketing team at Medicare that will assist the provider/biller in testing and follow up after implementation. The hotline is 410-561-4277.

Mr. Reese also spoke about Medicare's goal of percentage of EMC claims processed to the total claims processed and the importance of meeting these goals.

▼ **Diagnosis Coding**

Edith Sunderland, Professional Relations, spoke regarding the diagnosis coding mandate to code to the highest level of specificity. If the code used on the claim is not coded to the highest level of specificity, Medicare will develop the claim. The physician has 45 days to respond to the letter or the claim will be denied for lack of response. There are three codes causing specific concerns: (1) asthma; (2) hypertension; and (3) diabetes.

Ms. Sunderland encouraged providers to review carefully the tabular sections for these codes and to code to the highest level of specificity.

The committee addressed their concern regarding the purpose of the five digit code, the inconvenience, and the cost. A motion was made by the committee for the co-chair, Joseph Berkow, M.D., to draft a letter to HCFA about the concerns of the committee regarding the diagnosis coding mandate.

Ms. Sunderland also spoke about the oral cancer drug being processed by the DMERC, and surgical indicators on MFS.

▼ **Comparative Performance Reports (CPR)**

Dorothy Callahan, R.N., discussed the Comparative Performance Report for 1994. She informed the CAC that Medicare will be generating letters to providers who appear to be billing outside the norm in relation to their peers.

Physician billing will be compared to a peer group, defined as all physicians of the same specialty, in the same locality. A total of 98 reports will be sent prior to September 30, 1994. The program is informational and required by law.

▼ **Health Professional Shortage Area (HPSA)**

Madge Greely, R.N., spoke about the Health Professional Shortage Area (HPSA). The HPSA's are processed with a bonus incentive of 10%. Medicare is required to conduct quarterly audits on the HPSA's, forward the results to HCFA and recover overpayments.

▼ Questions & Answers

Dr. Barry Gold discussed questions proposed by the committee.

Why isn't Maryland reimbursing 90887 - other psychiatric therapy?

Maryland will start reimbursing 90887 as of 4/1/94. Dr. Gold expressed concerns to Dr. Lafferman regarding potential abuse of this code. The Maryland Psychiatric Society will provide input on guidelines to limit abuse of this code.

On procedure 90862, what is the documentation requirement?

90862 states pharmacological management with no more than minimal psychotherapy. Medicare does not provide documentation guidelines. Psychiatrists are encouraged to discuss guidelines with local and national societies for publication in CPT.

How should the M0064 code be used?

This code should be used when providers are evaluating patients solely for the purpose of drug management.

Dr. Gold agreed to formally meet with representatives of the Maryland Psychiatric Society to discuss these issues further.

▼ The meeting adjourned approximately 8:15 p.m.

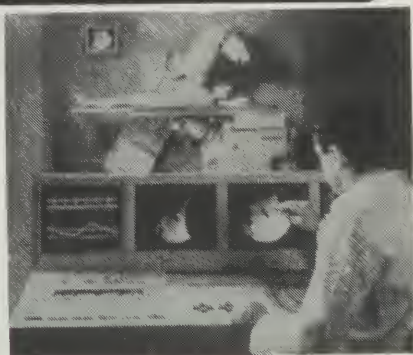
Respectfully submitted by:

Helene Shugart

Director, Medicare Carrier Operations

The next Carrier Advisory Committee meeting is scheduled on Wednesday, June 15, 1994 at 6:00 p.m. at the Timonium Holiday Inn, 2004 Greenspring Drive, Timonium, Maryland 21093.

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SECTION: Drugs and Biologicals

MEDICAL POLICY

SUBJECT: Chemotherapeutic Drug Coverage

EFFECTIVE DATE: June 3, 1993

REVISED: March 16, 1994

CPT/HCPCS CODE(S): Refer to list which begins on page two (2) for each chemotherapeutic agent. These are shown in ICD.9.CM "J" code order. An alphabetical listing is found on page sixteen (16).

DESCRIPTION OF SERVICE: Chemotherapy is the treatment of neoplastic disease by means of chemical substances or drugs.

COVERAGE REQUIREMENTS: An off-label use (also referred to as an unlabeled use) of a drug is a use that is not included as an appropriate indication on the drug's official label as approved by the FDA.

Effective January 1, 1994, unlabeled uses of FDA approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen for a medically accepted indication are considered safe and effective. (A regimen is a combination of anti-cancer agents which have been clinically recognized for the treatment of a specific type of cancer).

NOTE: A cancer treatment regimen does not include drugs used to treat toxicities or side effects of the treatment regimen.

A medically accepted indication is one of the following:

1. A use approved by the FDA (labeled indication).
2. A use supported by one or more citations in at least one of the three drug compendia listed below, and the use is not listed as "not" indicated in any of the three compendia:

Chemotherapeutic Drug Coverage

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- a. American Hospital Formulary Service Drug Information
 - b. American Medical Association Drug Evaluations
 - c. United States Pharmacopoeia Drug Information (USPDI).
3. A use supported by clinical research that appears in peer-reviewed medical literature. (This applies only when an unlabeled use does not appear in any of the compendia, or is listed as "insufficient data" or "DVP" or "investigational."

The following is a list of frequently prescribed chemotherapeutic drugs reimbursed by Medicare for cancer chemotherapy. Both labeled and approved off-labeled diagnoses are listed. Off-labeled uses of FDA-approved drugs not otherwise excluded (such as self-administered drugs) will usually be reimbursed. The use must be considered reasonable and necessary based on the coverage criteria described above.

ICD.9.CM Code(s):

The diagnoses and the appropriate ICD.9.CM Codes are listed for each chemotherapeutic agent.

Leucovorin - J0640 in combination with Fluorouracil - J9190

| | |
|-------------------------|------------------------------------|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colon and rectal cancer | 153.0-153.9, 154.0-154.8, 197.5 |
| Endometrial cancer | 182.0 |
| Gastric cancer | 151.0-151.4, 151.98, 197.4 |
| Head and neck cancer | 140.0-149.9 |
| Liver cancer | 201.00-201.90 |

Chemotherapeutic Drug Coverage

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| | |
|---|--|
| Lung cancer | 162.0-162.9 |
| Malignant pleural, peritoneal and pericardial effusion | 197.2, 197.6, 420.0, 420.90, 568.82 |
| Ovarian cancer | 183.0 |
| Prostate cancer | 185 |

Leucovorin - J0640 (rescue of high dose Methotrexate therapy)

| | |
|---|--|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Burkitt's lymphoma | 200.20-200.28 |
| Cervical cancer | 180.0-180.9 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteogenic sarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Prostatic cancer | 185 |
| Renal cancer | 189.0-189.1, 198.0 |
| Trophoblastic germ cell choriocarcinoma | 186.0, 186.9 |
| Trophoblastic germ cell testicular carcinoma | 186.0, 186.9 |

Doxorubicin (Adriamycin) - J9000, J9010

| | |
|--------------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 206.00 |
| Bladder cancer | 188.0-188.9 |
| Bone sarcomas | 170.0-170.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Ewing's sarcoma | 170.9 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Head and neck cancer | 140.0-149.9 |
| Liver cancer | 155.0-155.2, 197.7 |
| Hodgkin's disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Laryngeal cancer | 161.0-161.9 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |

Chemotherapeutic Drug Coverage

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| | |
|--|--|
| Multiple myeloma | 203.00 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Multiple myeloma | 203.00 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Neuroblastoma | 160.0-194.9 |
| Ovarian cancer | 183.0 |
| Pancreatic cancer | 157.0-157.9 |
| Prostate cancer | 185 |
| Soft tissue sarcomas | 171.0-171.9 |
| Trophoblastic germ cell testicular cancer | 186.0, 186.9 |
| Thymoma | 164.0 |
| Thyroid cancer | 193 |
| Uterine cancer | 182.0-182.8 |
| Vaginal cancer | 184.0 |
| Wilms' tumor | 189.0 |

Asparaginase- J9020 in combination with other antineoplastics (but not necessarily simultaneously)

| | |
|--------------------------------|--|
| Acute lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 205.80, 206.00, 206.80 |
| Chronic myelogenous leukemia | 205.10 |
| Chronic lymphocytic leukemia | 204.10 |
| Hodgkin's disease | 201.00-201.90 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

BCG (Bacillus Calmette - Guerin) - J9031

| | |
|-------------------------------|-------------|
| Bladder cancer | 188.0-188.9 |
| Melanoma (malignant melanoma) | 172.0-172.9 |

Bleomycin Sulfate - J9040

| | |
|----------------------|--------------------|
| Cervical cancer | 180.0,180.9 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Head and neck cancer | 140.0-149.9, 195.0 |
| Hodgkin's disease | 201.0-210.90 |

Chemotherapeutic Drug Coverage

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| | |
|---------------------------------|--|
| Kaposi's sarcoma | 042.2 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 280-202.88 |
| Osteosarcoma | 170.0-170.9 |
| Penile cancer | 187.1-187.4 |
| Renal cell cancer | 189.0-189.1 |
| Reticulum cell sarcoma | 200.00-200.88 |
| Soft tissue sarcoma | 171.0-171.9 |
| Squamous cell cancer of skin | 173.0-173.9 |
| Trophoblastic testicular cancer | 186.0, 186.9 |
| Thyroid cancer | 193 |

Carboplatin - J9045

| | |
|---|---|
| Bladder cancer | 188.0-188.9 |
| Breast Cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Esophageal cancer | 150.9, 197.8 |
| Gastrointestinal cancer | 151.0-151.4, 151.9, 159.0-159.1, 197.4 |
| Head and neck cancer (soft tissue malignant tumor) | 140.0-149.9, 195.0 |
| Laryngeal cancer | 161.0-161.9 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Merkel's tumor | 173.8-173.9 |
| Neuroblastoma | 160.0-194.0 |
| Orbital cancer | 190.1 |
| Osteosarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Prostate cancer | 185 |
| Testicular cancer | 186.0-186.9 |
| Thyroid cancer | 193 |
| Urethral cancer | 188.6, 189.1-189.4 |
| Uterine cancer | 182.0-182.8 |

Carmustine (BCNU)- J9050

| | |
|-------------------|--------------------------|
| Astrocytoma | 191.9 |
| Colorectal cancer | 153.0-154.8, 197.4-197.5 |
| Ewing's sarcoma | 170.9 |

Chemotherapeutic Drug Coverage

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| | |
|-------------------------------|---|
| Glioblastoma | 155.0-155.2, 197.7 |
| Liver cancer | 201.00-201.90 |
| Hodgkins' disease | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Medullablastoma | 191.6 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Multiple myeloma | 203.00 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

Cisplatin - J9060, J9062

| | |
|-------------------------------|--|
| Adrenal cortex cancer | 194.0 |
| Astrocytoma | 191.9 |
| Bladder cancer | 188.0-188.9 |
| Bone sarcomas | 170.0-170.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Head and neck cancer | 140.0-149.9 |
| Laryngeal cancer | 161.0-161.9 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Merkel's tumor | 173.8, 173.9 |
| Melanoma (Malignant Melanoma) | 172.0-172.9 |
| Mesothelioma | 158.0-158.8, 163.0-163.9 |
| Neuroblastoma | 160.0-194.0 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteosarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Penile cancer | 187.1-187.4 |
| Prostate cancer | 185 |
| Skin cancer | 173.0-173.9 |
| Soft tissue cancer (Sarcomas) | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |
| Thymoma | 164.0 |
| Urethral cancer | 188.6, 189.1-189.4 |
| Uterine cancer | 182.0-182.8 |

Chemotherapeutic Drug Coverage

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Cyclophosphamide (Cytosan) - J9070, J9080, J9090, J9091, J9092, J9094, J9095, J9096, J9097

| | |
|--|---|
| Acute Lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 205.80, 206.00, 206.80 |
| Bladder cancer | 188.0-188.9 |
| Cervical cancer | 180.0-180.9 |
| Endometrial cancer | 182.0 |
| Ewing's sarcoma | 170.9 |
| Head and neck cancer | 140.0-149.9 |
| Hodgkin's disease | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Multiple Myeloma | 203.00 |
| Neuroblastoma | 160.0-194.0 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80 202.88 |
| Osteosaroma | 170.0-170.9 |
| Ovarian cancer (germ cell and non-germ cell) | 183.0 |
| Prostate cancer | 185 |
| Retinoblastoma | 190.5 |
| Soft tissue cancer | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |
| Uterine cancer | 182.0-182.8 |
| Wilms' tumor | 189.0 |

Cytarabine (Cytosar) - J9100, J9110

| | |
|-----------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute myelocytic leukemia | 205.00 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Hodgkin's disease | 201.00-201.90 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

Dactinomycin (Actinomycin D) - J9120

| | |
|-------------------------------|-------------|
| Acute lymphocytic leukemia | 204.00 |
| Breast cancer | 174.0-175.9 |
| Endometrial cancer | 182.0 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Ovarian cancer | 183.0 |
| Rhabdomyosarcoma | 171.0-171.9 |
| Sarcomas | 171.0-171.9 |

Chemotherapeutic Drug Coverage

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| | |
|-------------------------------|--------------|
| Testicular cancer | 186.0, 186.9 |
| Trophoblastic tumors in women | 181 |
| Wilms' tumor | 189.0 |

Dacarbazine (DTIC) - J9130, J9140

| | |
|--------------------|--------------------|
| Hodgkin's disease | 201.00-201.90 |
| Malignant Melanoma | 172.0-172.9 |
| Neuroblastoma | 160.0-194.9 |
| Pancreatic cancer | 157.0-157.9, 197.8 |
| Sarcomas | 171.0-171.9 |

Daunorubicin - J9150

| | |
|--------------------------------|--|
| Acute lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 206.00 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Ewing's sarcoma | 170.9 |
| Neuroblastoma | 160.0-194.9 |
| Non-Hodgkin's lymphoma | 200.00-200., 202.00-202.08, 202.80-202.88 |
| Rhabdomyosarcoma | 171.0-171.9 |
| Wilms'tumor | 189.0 |

Diethylstilbestrol Diphosphate - J9165

| | |
|------------------|-------------|
| Breast cancer | 174.0-175.9 |
| Prostatic cancer | 185 |

Etoposide (VP16) - J9181, J9182

| | |
|----------------------------------|---------------------------|
| Acute lymphocytic leukemia | 204.00 |
| Acute myelocytic leukemia | 205.00, 206.00 |
| Adrenal cortex cancer | 194.0 |
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Ewing's sarcoma | 170.9 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Germ cell ovarian cancer | 181 |
| Gestational trophoblastic cancer | 186.0, 186.9 |
| Glioma-Brain | 191.1 |

Chemotherapeutic Drug Coverage

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| | |
|----------------------|--|
| Hodgkin's disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Liver cancer | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |
| Soft tissue sarcomas | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |

Fluorouracil (5-FU) - J9190

| | |
|--------------------|---------------------------|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colorectal Cancer | 153.0-154.8, 197.4-197.5 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Lung cancer | 162.0-162.9 |
| Ovarian cancer | 183.0 |
| Pancreatic cancer | 157.0-157.9, 197.8 |
| Prostate cancer | 185 |

Floxuridine (FUDR) - J9200

| | |
|--|---------------------------|
| Acute lymphocytic leukemia | 205.00, 206.00 |
| Acute myelocytic leukemia | 205.00, 206.00. |
| Bile duct cancer | 155.1, 156.1-156.9 |
| Bladder cancer | 188.0-188.9 |
| Brain cancer | 191.0-191.9, 192.1 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colorectal cancer | 153.0-154.8, 197.4-197.5 |
| Gall bladder cancer | 153.0-154.8, 197.4-197.5 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| GI adenocarcinoma metastatic to liver | 155.2, 159.9 |
| Head and neck cancer | 140.0-149.9, 195.0 |

Chemotherapeutic Drug Coverage

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| | |
|-----------------|---------------|
| Liver cancer | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Ovarian cancer | 183.0 |
| Prostate cancer | 185 |

Goserellin Acetate (Zoladex) - J9202

| | |
|-------------------------------|-------------|
| (Advanced) prostate cancer | 185 |
| (Premenopausal) breast cancer | 174.0-175.9 |

Ifosfamide - J9208

| | |
|--|---|
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Connective and other soft tissue malignancies | 171.0-171.9 |
| Endometrial cancer | 182.0 |
| Ewing's sarcoma | 170.9 |
| Germ cell testicular cancer | 186.0, 186.9 |
| Hodgkin's disease | 201.00-201.90 |
| Leukemias (acute) | 204.0, 205.00, 206.00 |
| Lung cancer | 162.0-162.9 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |
| Pancreatic cancer | 157.0-157.9, 197.8 |
| Sarcomas | 171.0-171.9 |

Interferon - J9213-J9216

| | |
|--|--------------------|
| Bladder cancer | 188.0-188.9 |
| Brain cancer | 191.0-191.9, 192.1 |
| Cervical cancer | 180.0-180.9 |
| Chronic myelogenous leukemia | 205.10 |
| Chronic lymphocytic leukemia | 204.10 |
| Hairy cell leukemia | 202.40-202.48 |
| Head and neck cancer | 140.0-149.9 |
| Hepatitis C | 070.51 |
| Hepatitis B | 070.30 |
| Hodgkin's disease | 201.00-201.90 |
| Internal and external genital warts | 078.1 |
| Kaposi's sarcoma | 042.2 |

Chemotherapeutic Drug Coverage

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| | |
|-------------------------------|--|
| Malignant melanoma (Melanoma) | 172.0-172.9 |
| Multiple myeloma | 185 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteosarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Skin cancer | 173.0-173.9 |
| Renal cell carcinoma | 190.0, 189.1 |

Mechlorethamine HCL (Nitrogen Mustard - J9230

| | |
|------------------------------|---|
| Brain cancer | 191.0-191.9, 192.1 |
| Breast cancer | 174.0-175.9 |
| Chronic lymphocytic leukemia | 204.10 |
| Chronic myelocytic leukemia | 205.10 |
| Hodgkin's disease | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Lymphosarcoma | 200.00-200.18, 200.80-200.88 |
| Non-Hodgkin's lymphomas | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |
| T-cell lymphoma, cutaneous | 173.0-173.9, 202.00 |

Medroxyprogesterone acetate (Depo-provera) - J9240

| | |
|--------------------|--------------------|
| Breast cancer | 174.0-175.9 |
| Endometrial cancer | 182.0 |
| Renal cancer | 189.0-189.1, 198.0 |

Mesna - J9209

Given with Ifosfamide or Cytosan (refer to diagnoses listed under these chemotherapeutic agents).

Methotrexate - J9250, J9260

| | |
|-----------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute myelocytic leukemia | 205.00, 205.80, 206.00, 206.80 |
| Cutaneous T-cell lymphoma | 173.0-173.9, 202.00 |
| Gestational choriocarcinoma | 263.1 |
| Lymphosarcoma | 185 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteosarcoma | 170.0-170.9 |

Chemotherapeutic Drug Coverage
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| | |
|---|--|
| Sarcomas | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |
| Trophoblastic tumors | 186.0, 186.9 |
| Also used in combination with other antineoplastics for, bladder, brain, breast, cervical esophageal, gastric, head and neck, liver, lung, ovarian and prostate cancer. | Refer to diagnosis codes listed under these chemotherapeutic agents. |

Plicamycin (Mithramycin) - J9270

| | |
|----------------------|-------------|
| Testicular carcinoma | 186.0-186.9 |
|----------------------|-------------|

Mitomycin - J9280, J9290, J9291

| | |
|-----------------------------|---|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 188.0-188.9 |
| Cervical cancer | 180.0-180.9 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Colorectal cancer | 153.0-154.8, 197.4-197.5 |
| Esophageal cancer | 150.9, 197.8 |
| Gallbladder cancer | 156.0, 156.8 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Head and neck cancer | 140.0-149.9 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Pancreatic cancer | 157.0-157.9, 197.8 |

Mitoxantrone (Novantrone - J9293)

| | |
|--------------------------------|---|
| Acute non-lymphocytic leukemia | |
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Endometrial cancer | 182.0 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Liver cancer | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |
| Pancreatic cancer | 157.0-157.8, 197.8 |

Chemotherapeutic Drug Coverage
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| | |
|--|--------------|
| Prostate cancer | 185 |
| Sarcomas | 171.0-171.9 |
| Squamous cell cancer of head and neck | 140.0-149.9 |
| Testicular cancer | 186.0, 186.9 |
| Thyroid cancer | 193 |

Streptozocin - J9320

| | |
|--|--------------------------|
| Acute lymphocytic leukemia | 205.00, 206.00 |
| Corectal cancer | 153.0-154.8, 197.4-197.5 |
| Hodgkin's disease | 201.00-201.90 |
| Liver cancer | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Metastatic islet cell carcinoma of pancreas | 157.4 |

Thiotepa - J9340

| | |
|-------------------------|---|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Hodgkin's disease | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Meningeal cancer | 198.4 |
| Non-Hodgkin's lymphomas | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |

Vinblastine Sulfate (Velban) - J9360

| | |
|-----------------------------|----------------|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Germ cell testicular cancer | 186.0, 186.9 |
| Head and neck cancer | 140.0-149.9 |
| Hodgkin's Disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Kidney cancer | 189.0, 189.1 |
| Lung cancer | 162.0-162.9 |
| Melanoma | 172.0-172.9 |
| Mycosis Fungoides | 202.10-202.18 |

Chemotherapeutic Drug Coverage

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| | |
|-------------------------|---|
| Neuroblastoma | 160.0-194.0 |
| Non-Hodgkin's lymphomas | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| T-cell lymphoma | 173.0-173.9, 202.00 |

Vincristine Sulfate (Oncovin) - J9370, J9375, J9380

| | |
|-----------------------------------|--|
| All leukemias (acute and chronic) | 204.00-204.90, 205.00-205.90, 206.00-206.90, 207.00, 207.80, 208.00-208.90 |
| Brain cancer | 191.0-191.9, 192.1 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colorectal cancer | 153.0-154.8, 197.4-197.5 |
| Ewing's sarcoma | 170.9 |
| Head and neck cancer | 140.0-149.9 |
| Hodgkin's disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Lung cancer | 162.0-162.9 |
| Non-Hodgkin's lymphomas | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteogenic and other sarcomas | 170.0-170.9, 202.00-202.08, 202.60-202.68 |
| Renal cancer | 189.0-189.1, 198.0 |
| Rhabdomyosarcoma | 171.0-171.9 |
| T-cell lymphoma | 173.0-173.9, 202.00 |
| Wilms' tumor | 189.0 |

Fludarabine - J9999

| | |
|------------------------------|---|
| Chronic lymphocytic leukemia | 204.10 |
| Myeloma | 185 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

Idarubicin - J9999

| | |
|--------------------------|----------------|
| Acute monocytic leukemia | 206.00 |
| Acute myeloid leukemia | 205.00, 206.00 |

Leukine (Sargramostim) - Q0094

| | |
|---|--------------------------|
| Acute lymphoblastic leukemia | 205.00, 206.00 |
| Hodgkin's disease undergoing autologous bone marrow transplantation | 201.00-201.90 with V42.4 |

Chemotherapeutic Drug Coverage
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Non-Hodgkin's lymphoma 200.00-200.88, 202.00-202.08,
202.80-202.88

Billing Instructions:

Effective January 1, 1994 claims for oral anti-cancer drugs submitted by a supplier are processed by the appropriate regional carrier. Refer to the regional carrier's medical policy guidelines.

Claims for oral anti-cancer drugs submitted by a provider are processed by the appropriate fiscal intermediary (FI). The term provider here includes hospitals, rural primary care hospitals, skilled nursings facilities comprehensive out-patient rehabilitation facilities, home health agencies and hospice programs.

Claims for injectable anti-cancer drugs furnished incident to a physician's service - and not self-administered-continues to be processed by this carrier.

Barry S. Gold M.D.

Approved by: _____

Barry S. Gold, M.D., F.A.C.P.
Medical Director

Provider Notification:

Revised policy guidelines which include ICD.9.CM codes to Carrier Advisory Committee (CAC) March 16, 1994.

chemo.wp

Chemotherapeutic Drug Coverage

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ALPHA INDEX CHEMOTHERAPEUTIC AGENTS

| | |
|--|---|
| Asparaginase | J9020 |
| BCG (Bacillus Calmette-Guerin) | J9031 |
| Bleomycin Sulfate | J9040 |
| Carboplatin | J9045 |
| Carmustine (BCNU) | J9050 |
| Cisplatin | J9060, J9062 |
| Cyclophosphamide (Cytosan) | J9070, J9080, J9090, J9091, J9092, J9094, J9095, J9096, J9097, |
| Cytarabine (Cytose) | J9100, J9110 |
| Dactinomycin (Actinomycin D) | J9120 |
| Dacarbazine (DTIC) | J9130, J9140 |
| Daunorubicin | J9150 |
| Diethylstilbestrol Diphosphate | J9165 |
| Doxorubicin (Adriamycin) | J9000, J9010 |
| Etoposide (VP16) | J9181, J9182 |
| Floxuridine (FUDR) | J9200 |
| Fludarabine | J9999 |
| Fluorouracil (5-FU) | J9190 |
| Goserelin Acetate (Zoladex) | J9202 |
| Idarubicin | J9999 |
| Ifosfamide | J9208 |
| Interferon | J9213, J9216 |
| Leucovorin | J0640 |
| Leucovorin (in combination with Fluorouracil) | J9190 |
| Leucovorin (rescue of high dose methotrexate therapy) | J0640 |
| Leukine (Sargramostim) | Q0094 |
| Mechlorethamine HCL (nitrogen mustard) | J9230 |
| Medroxyprogesterone Acetate (Depo - provera) | J9240 |
| Mesna | J9209 |
| Methotrexate | J9250, J9260 |
| Mitomycin | J9280, J9290, J9291 |
| Mitoxantrone (Novantrone) | J9293 |
| Neupogen (Filgrastim) | Q0093 |
| Pentostatin | J9999 |
| Plicamycin (Mithramycin) | J9270 |
| Proleukin | J9270 |
| Streptozocin | J9320 |
| Taxol | J9999 |
| Thiotepa | J9340 |
| Vinblastine Sulfate (Velban) | J9360 |
| Vincristine Sulfate (Oncovin) | J9370, J9375, J9380 |

Chemotherapeutic Drug Coverage

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HCPCS - INDEX CHEMOTHERAPEUTIC AGENTS

| | |
|---------------------|---|
| J0640 - | Leucovirin |
| J0640 - | Leucovirin (rescue of high dose methotreate therapy) |
| J9000 - | Doxorubin (Adriamycin) |
| J9010 - | Doxorubin (Adriamycin) |
| J9020 - | Asparaginase (in combination with other Antineoplastics but not NE) |
| J9031 - | BCG (Bacillus Calmette - Guerin) |
| J9040 - | Bleomycin Sulfate |
| J9045 | Carboplatin |
| J9050 - | Carmustine (BCNU) |
| J9060, J9062 | Cisplatin |
| J9070, J9080, J9090 | Cyclophusphamide (Cytosan) |
| J9091, J9096, J9097 | |
| J9100, J9110 - | Cytarabine (Cytosr) |
| J9120 - | Dactinomycin (Actinomycin D) |
| J9130, J9140 - | Dacarbazine (DTIC) |
| J9150 - | Daunorubicin |
| J9165 - | Diethylstilbestrol Diphosphate |
| J9181, J9182 | Etoposide (VP16) |
| J9190 - | Fluorouracil, Leucovorin (in combination with fluorouracil) |
| J9202 - | Gosserellin Acetate (Zoladex) |
| J9208 | Ifosfamide |
| J9213, J9216 - | Interferon |
| J9230 - | Mechlorethamine HCL (Nitrogen Mustard) |
| J9240 | Medroxyprogesterone Acetate (Depo-Provera) |
| J9250, J9260 - | Methotrexate |
| J9270 - | Plicamycin (Mithramycin) |
| J9280, J9290, J9291 | Mitomycin |
| J9293 - | Mitroxantrone (Novantrone) |
| J9320 - | Streptozocin |
| J9340 - | Thiotepa |
| J9360 - | Vinblastine Sulfate (Velban) |
| J9370, J9375, J9380 | Vincristine Sulfate (Oncouin) |
| J9999 - | Fludarabine, Idarubicin, Pentostatin, Proleukin Taxol |
| Q0093 - | Neupogen (Filgastrim) |
| Q0094 - | Leukine (Sargramostim) |

The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

- **Manuscript preparation**—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated.

Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- **Permissions**—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the *MMJ* to reproduce the information/figure.

- **Editorial responsibility**—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- Managing emergency medical services**, at the University of Maryland in Baltimore County. July 5–29
Info: Dr. Richard Bissell, 410-455-3776.
- R. Adams Cowley 16th annual national trauma symposium**, at the Hyatt Regency, in Baltimore, Maryland. Nov. 16–20
Info: 410-328-2399.

Miscellaneous meetings

- Pediatric cardiac catheterization update—1994**, sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. May 2–4
- Challenge of improving health care in the city**, sponsored by the Baltimore City Medical Society, at James Lawrence Kernan Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: Free. Info: 410-625-0022. May 5
- Two-dimensional and Doppler echocardiography for the technologist**, sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. May 9–11
- 46th annual meeting and scientific session**, sponsored by the Maryland Academy of Family Physicians, in Ocean City, Maryland. 41.25 Cat 1 AMA/PRA credits; 41.25 AAFP prescribed hours. Fee: \$240 members; \$275 nonmembers; \$135 paramedicals; free for residents, medical students, MAFP retired and life members. Info: Richard Colgan, M.D., 410-747-1980. May 10–15
- Clinical auscultation of the heart**, sponsored by the American College of Cardiology, at the Georgetown University Medical Center, in Washington DC. 18 Cat 1 AMA/PRA credits. Info: 301-897-2695. May 11–13
- Medical and Chirurgical Faculty of Maryland's Annual Meeting** at the Ramada Inn and Convention Center, in Hagerstown, Maryland. 14 Cat 1 AMA/PRA credits. Fee: Free for Med Chi members. Info: Joan Mannion, 410-539-0872 or 800-492-1056. May 12–14
- Two-D/Doppler and color-flow imaging: a clinical review with emphasis on TEE, stress echocardiography, and Doppler hemodynamics**, sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. May 12–14
- Peripheral artery disease: contemporary strategies for diagnosis and therapy**, sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. May 18–20
- Cardiac transplantation: state-of-the-art**, sponsored by the American College of Cardiology, at the Heart House Learning Center, in Bethesda, Maryland. Info: 800-257-4737. May 23–25
- Aggressive management of cardiovascular emergencies: Featuring the role of echocardiography**, sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. June 1–3

Miscellaneous meetings (continued)

| | |
|---|-------------------|
| Modern advances in the treatment of pain , sponsored by the Baltimore City Medical Society, at St. Agnes Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: free. Info: 410-625-0022. | June 2 |
| Obstetrics dilemmas in the era of managed health care , sponsored by the Eastern Virginia Medical School, at the Sheraton Inn Oceanfront, in Virginia Beach, Virginia. Cat 1 AMA/PRA credits available. Info: Jeanette Schmitz, 804-446-6143. | June 3-4 |
| Pediatrics Cardiology update , sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. | June 6-8 |
| Cardiovascular pharmacology-1994 , sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. | June 9-11 |
| Intensive review of internal medicine , sponsored by the George Washington University Medical Center, at the the Washington Marriott, Washington, DC. Info: Todd Belfield, 202-994-4285. | June 11-14 |
| Second annual board review in family medicine , sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, in Arlington, Virginia. Info: Daniel Reichard, 202-994-4285. | June 11-15 |
| The Medical and Surgical treatment of macular disorders , sponsored by the University of Maryland School of Medicine and the Retina Institute of Maryland, at the Marriott, in Annapolis, Maryland. 6 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$100 fellows and allied health professionals. Info: 410-337-4500. | June 17 |
| 10th annual meeting of the International Society of Technology Assessment in Health Care , sponsored by the George Washington University Medical Center, at Stouffer Harborplace, Baltimore, Maryland. Info: Maria Gorrick, 202-994-4285. | June 19-22 |
| Exercise expired gas analysis, nuclear cardiology, and echocardiography: the noninvasive assessment of ischemic heart disease , sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. | June 22-24 |
| Twelfth summer symposium in internal medicine , sponsored by the Eastern Virginia Medical School, at the Holiday Day on the Ocean, Virginia Beach, Virginia. 15.5 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$195 resident, nurse, allied health. Info: Ann McClanahan, 804-446-6141. | June 24-26 |
| Annual meeting of the Bolivian Medical Society , sponsored by the George Washington University Medical Center, in Arlington, Virginia. Info: Todd Belfield, 202-994-4285. | Aug. 4-7 |
| Women's health research topic , sponsored by the Baltimore City Medical Society at the Montebello Rehabilitation Hospital. 1 Cat 1 AMA Credit, Fee: Free. Info: 410-625-0022. | Sept. 1 |
| Hematology board review course , sponsored by the George Washington University Medical Center, at the Ritz-Carlton, in Pentagon City, Virginia. Info: Maria Gorrick, 202-994-4285. | Oct. |
| Network approach to provision of health care , sponsored by the Baltimore City Medical Society at the Good Samaritan Hospital. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. | Oct. 6 |
| Psycho-economics: clinical psychiatry and health care reform in the 1990s , sponsored by the American Psychiatric Association, in Baltimore, Maryland. 34 Cat 1 AMA/PRA credits. Info: 202-682-6174. | Oct. 8-12 |

Miscellaneous meetings (continued)

Annual business meeting, sponsored by the Baltimore City Medical Society at UMMS Davidge Hall. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. **Nov. 3**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, Maryland. Info: 301-279-6115.

| | |
|--|----------------|
| Ophthalmic plastic and reconstructive surgery | May 5 |
| Tumor conference | May 12 |
| 1993 revised classification system for HIV infection and expanded surveillance; case definition for AIDS | May 19 |
| Tumor conference | June 9 |
| Ischemic heart disease | June 16 |
| Current therapy of obesity | June 23 |
| Palliative care across the disease spectrum | June 30 |
| Dermatosis of pregnancy | July 7 |
| Tumor conference | July 14 |
| Recent perinatal advances in the evaluation of the fetus | July 28 |

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

| | |
|---|-------------------|
| Pediatric allergy and immunology for the practitioner. Cat 1 AMA/PRA credits available. Fee: TBA. | May 5–6 |
| Phototherapy and photochemotherapy. 10 Cat 1 AMA/PRA credits. Fee: \$250 physicians; \$200 nurses and technicians; \$150 residents and fellows. | May 6–7 |
| Optional strategies for treating peripheral vascular disease: a debate. Cat 1 AMA/PRA credits available. Fee: \$25. | May 7 |
| 21st century retina: what's hot, hype, and hard fact. 8 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$100 residents, fellows, and allied health professionals. | June 10 |
| The seventh summer institute on environmental health sciences. Cat 1 AMA/PRA credits available. Info: Denis Barton, 410-955-3537 or Kay Castleberry, 410-955-2212. | June 6–17 |
| Principles and practices of data management for clinical trials. Cat 1 AMA/PRA credits available. Fee: TBA. | June 16–17 |
| Advanced pediatric life support courses. 20 Cat 1 AMA/PRA credits; 18.5 AAFP prescribed hours; 20 AAP credit hours; 17 ACEP Cat 1 credits. Fee: \$525. | June 13–15 |

The Johns Hopkins Medical Institutions (continued)

- | | |
|---|--------------------|
| Johns Hopkins third annual update on obstetric anesthesia plus an optional fiberoptic airway management workshop. 12 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$75 residents and fellows; one-day fees available. | Aug. 13-14 |
| Airway management: hands on workshops, case management colloquia, and difficult airway/intubation alert. Cat 1 AMA/PRA credits available. Fee: \$650. | Sept. 23-25 |
| 20th anniversary: annual topics in gastroenterology and liver disease. Cat 1 AMA/PRA credits available. Fee: \$495 physicians; \$250 residents and fellows (with letter from department chairperson verifying status). | Oct. 5-7 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA/PRA credits available. Fee: \$500 lectures; \$400 each additional lab; \$200 lectures for fellows and allied health professionals. | Oct. 24-26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27-30 |

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Johns Hopkins sports medicine grand rounds.** Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

Med Chi Bicentennial Celebrations

Med Chi has already begun planning celebration activities for its bicentennial in 1999. If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at 410-539-0872 or 1-800-492-1056.



EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

April 1994

Questions and Answers Relating to OSHA/MOSH Policy on Tuberculosis (TB)

The following was developed in response to common questions and concerns received by the Division of Tuberculosis Control, Epidemiology and Disease Control Program.

TB Surveillance, Evaluation and Management

Question 1: How should the Mantoux tuberculin skin test be interpreted in persons with a history of Bacillus Calmette-Guerin (BCG) vaccination?

Answer: Many foreign countries still use BCG as part of their tuberculosis control programs, especially for infants. Purified protein derivative (PPD) sensitivity and immunity to TB infection after BCG vaccination is highly variable, depending upon the strain of BCG used and the population vaccinated, so that there is no reliable method of distinguishing a PPD reaction caused by BCG vaccination from those caused by natural infections. The Centers for Disease Control and Prevention recommends that a positive PPD reaction in a person who was vaccinated with BCG, be interpreted as evidence of infection with *M. tuberculosis*. Such persons should be evaluated for isoniazid preventive therapy.

Question 2: Who should be considered a TB suspect?

Answer: A diagnosis of tuberculosis should be considered in anyone with a cough lasting more than 3 weeks which is productive or is associated with at least one other symptom suggestive of TB, such as blood in sputum, fever, night sweats, or unexplained weight loss.

Question 3: For health care workers who report a history of positive PPD skin tests, should the PPD be repeated?

Answer: PPD skin tests do not need to be repeated if there is written documentation of a previously positive reaction, or of completion of adequate preventive therapy, or of completion of adequate therapy for active disease. Repeating a PPD on an individual with a history of a previous positive PPD may result in a very pronounced reaction to the skin test.

Question 4: How often do employees with a previously positive PPD skin test need a chest x-ray? Who should pay for them?

Answer: Employees with previously known positive PPD skin test reactions followed by a documented chest x-ray that is negative do not need repeat chest x-rays regardless of the time elapsed since their negative chest x-ray. Repeat chest x-rays are only indicated when an employee has symptoms suggestive of TB and the employer is responsible for paying for the x-ray in such instances. Employees with positive PPD should be counseled to report any symptoms of TB.

Question 5: Are employers financially responsible for the cost of pre-employment skin testing and follow-up (e.g., chest x-ray, preventive therapy)?

Answer: Employers are financially responsible

for pre-employment skin testing and follow-up chest x-ray if indicated, but not for preventive therapy or treatment. Once a person is employed, the employer is expected to provide PPD skin testing free of charge to the employee; if the PPD skin test converts to positive while the employee is employed, then the employer is also financially responsible for the cost of chest x-ray, and sputum culture. Health insurance or workers compensation are responsible for TB prevention and treatment.

Question 6: Can an employee be penalized or fired for refusing a PPD skin test or a chest x-ray when indicated, or for refusing preventive medication if placed on INH?

Answer: This is a labor/management issue. An employer could make TB evaluation and management a condition of the job. Maryland Department of Health and Mental Hygiene (DHMH) does not force employees to undergo skin testing or INH preventive therapy at this time. If an employee refuses to undergo a PPD skin test or a chest x-ray, a signed waiver should be documented.

Question 7: Can employers have the cost of medical management of a TB infected employee billed to the person's private insurance?

Answer: No. OSHA describes "medical management" as medical care provided up to an including diagnosis. After the diagnosis is made however, the responsibility for payment for further care is that of personal medical insurance or workers compensation.

Question 8: Do health care employers who share airspace in the same building with a non-health care employer have responsibility for TB surveillance for all employees in the building?

Answer: No. The employer is responsible however, for creating a safe work environment. Health care employers have the responsibility to provide adequate engineering controls to prevent TB transmission. High risk areas should be vented directly to the outside and exhaust air should not be recirculated. MOSH may cite employers if inadequate airflow or ventilation are found to be the source of TB transmission.

Question 9: Must all employees of a health care setting (e.g., local health department) meet the requirements of the OSHA/MOSH policy?

Answer: No. Employees are not automatically covered under the OSHA/MOSH TB policy merely because the employer is a health care provider. For example, administrators and clerks employed by a local health department (LHD) who work in an administration building which is separate from the building where clinics are held and who do not have potential exposure to TB, do not have to be tuberculin skin tested. However, school nurses who are employed by a local health department who work exclusively in a separate building (i.e., schools) may be covered because of the potential for exposure to TB while providing services to sick children.

AFB (acid fast bacilli) Isolation

Question 10: How long should a patient with infectious tuberculosis remain in an AFB isolation room?

Answer: The length of time required for a patient to become noninfectious after starting antituberculous therapy varies considerably. Tuberculosis isolation should be discontinued only when the patient is on effective therapy, is improving clinically, and the sputum smear is negative for AFB on three consecutive days. For multiple drug-resistant (MDR) TB cases, AFB isolation should be discontinued only after cultures are negative after three consecutive days.

Question 11: What constitutes an AFB isolation room? What types of professionals can certify the adequacy of an AFB isolation room?

Answer: To meet CDC and DHMH requirements, rooms for AFB isolation must have:

- ▶ negative air pressure (air should flow into AFB isolation rooms from adjacent areas),
- ▶ at least six air changes per hour,
- ▶ good air mixing within the room,
- ▶ exhaust of contaminated air to outside and away from air supply intake,
- ▶ doors kept closed at all times, and
- ▶ frequent monitoring of air-flow direction.

In addition, inpatient rooms must be single occupancy with an attached bath. Anterooms are

preferred, but not required.

MOSH does not require that AFB isolation rooms be certified. Professionals such as industrial hygienist; heating, ventilation, and air conditioning specialists; or environmental/occupational health and safety officers should be able to verify the adequacy of an AFB isolation room.

Work Restrictions

Question 12: When can an employee diagnosed with tuberculosis disease return to work?

Answer: Employees with pulmonary or laryngeal tuberculosis pose a risk to patients and other employees while they are infectious; therefore, they should be excluded from work until adequate treatment is instituted, cough is resolved, and sputum is free of bacilli on three consecutive smears. Employees with MDR-TB should be excluded from work until three consecutive negative cultures and reassigned if their work involves care of high risk patients (e.g., HIV or other immunocompromised patients, patients in a neonatal intensive care unit).

Employees with tuberculosis at sites other than the lung or larynx usually do not need to be excluded from work. Employees who discontinue treatment before the recommended course of therapy has been completed should not be allowed to work until treatment is resumed, and adequate response to therapy is documented, and they have negative sputum smears on three consecutive days.

Employees with TB infection who cannot take or do not accept or complete a full course of preventive therapy do not need to be excluded from work, but they should be counseled about the risk of developing active TB and should be instructed on a regular basis to seek evaluation promptly if symptoms develop that may be due to TB, especially if they have exposure to high risk patients (i.e., patients at high risk for developing TB if they become infected with *M. tuberculosis*, such as patients who are HIV infected.)

Respiratory Protection

Question 13: Can disposable HEPA respirators be reused?

Answer: Disposable HEPA respirators can be reused except when they show: signs of damage or deterioration (including loss of shape), damage around the seal, a tear or rupture, or when there is increased difficulty in breathing while wearing the respirator.

Question 14: How should HEPA respirators be discarded?

Answer: HEPA respirators can be discarded as regular trash; OSHA does not require HEPA respirators to be discarded in a biohazard container.

Question 15: What respirators are NIOSH approved for TB protection?

Answer: Respirators with high efficiency particulate air (HEPA) filters are the only currently available certified respirators approved by NIOSH (48 CFR 1910.134) for protection against *M. tuberculosis*. Masks with a higher level of certification than the HEPA filters can also be used.

Question 16: How should a patient with infectious TB be safely transported?

Answer: Only surgical masks or particulate respirators without exhalation valves, and not a HEPA respirator, should be used on patients with TB. Employees transporting patients with TB should wear a HEPA respirator.

Question 17: Can employers discipline employees for failing to use HEPA respirators in situations where they are required?

Answer: Yes. Employers must enforce use in situations where HEPA respirators are required. Employees with a medical reason not to use HEPA respirators must be fitted with alternative NIOSH-approved respiratory protection or be reassigned.

Nursing Home

Question 18: Is two step PPD skin testing recommended for employees?

Answer: DHMH does not recommend routine

two step testing for employees, however, employers may adopt this method for use.

Question 19: When is two step PPD testing required?

Answer: Nursing home regulations require that "tuberculosis surveillance shall include, as appropriate, a chest x-ray or two-step tuberculin skin test by the Mantoux method using five tuberculin units of purified protein derivative." Therefore, when a skin test is indicated, a two step testing should be performed on all patients as a requirement for admission to reduce the likelihood that a boosted reaction is misinterpreted as a new infection.

Question 20: Can a nursing home readmit a patient with a positive AFB culture?

Answer: Yes, a nursing home patient with a positive AFB can be readmitted, but only after the patient has had three negative smears taken at least 24 hours apart, remains on effective therapy, and is improving clinically. Nursing home patients who have an initially negative PPD at the time of admission, should have a second test 1 to 3 weeks later. If the second test is positive, this is most likely a boosted reaction, and the person should be classified as previously infected. If the second test remains negative, the person is classified as uninfected. A positive reaction to a subsequent test is likely to represent a new infection with M. tuberculosis in the interval.

Question 21: For a patient with a history of a positive PPD skin test, how recent a chest x-ray is required for admission into a nursing home?

Answer: A chest x-ray should have been taken within 3 months if the patient has no respiratory symptoms.

Engineering Controls

Question 22: Are ultraviolet lights required?

Answer: No.

Question 23: Can fans in the window provide adequate negative pressure?

Answer: Yes, but the air exhausted from an AFB isolation room must either be filtered or exhausted

at least 25 feet from air intakes, walk ways, and windows to other rooms.

Question 24: When should a tuberculosis suspect be reported to the local health department?

Answer: A tuberculosis suspect should be reported to the local health department when there is a strong clinical suspicion of tuberculosis (see question #2) or when the patient has a positive AFB smear.

Question 25: Should individuals with only a positive skin test be reported to the health department?

Answer: No, except if there is a cluster of skin test conversions.

Miscellaneous

Question 26: Are hospitals required to admit a tuberculosis patient when Maryland Department of Health and Mental Hygiene requests admission?

Answer: No, hospitals are not required to admit a patient with TB. However, the historically close relationship and cooperation between health departments and hospitals have benefitted public health.

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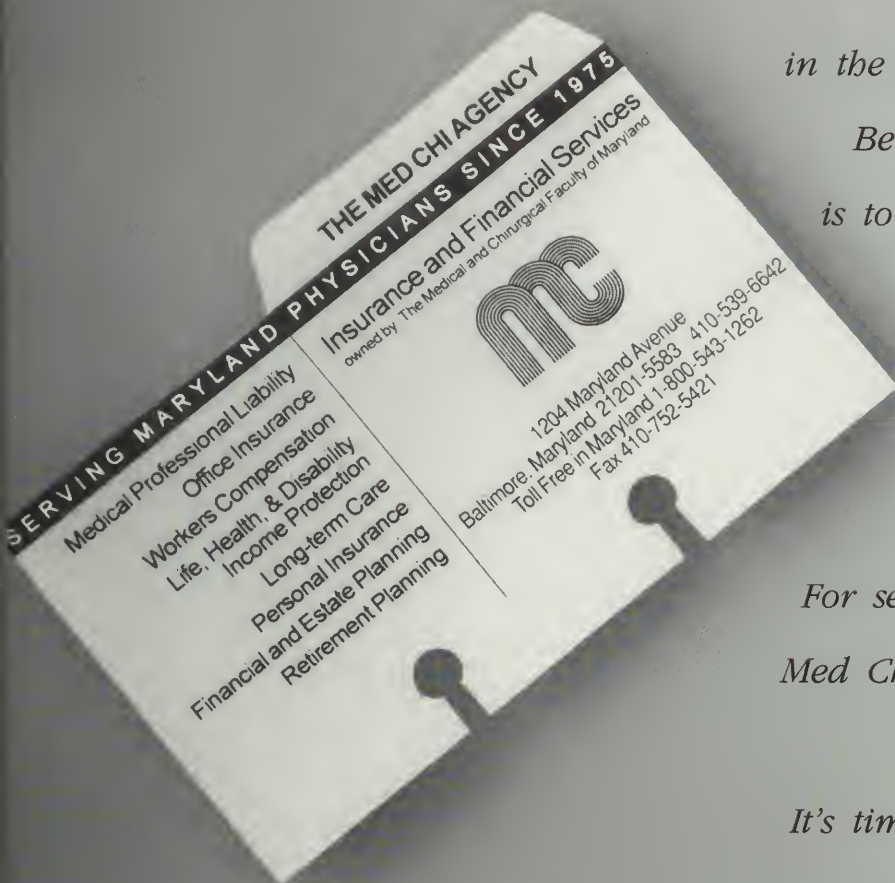
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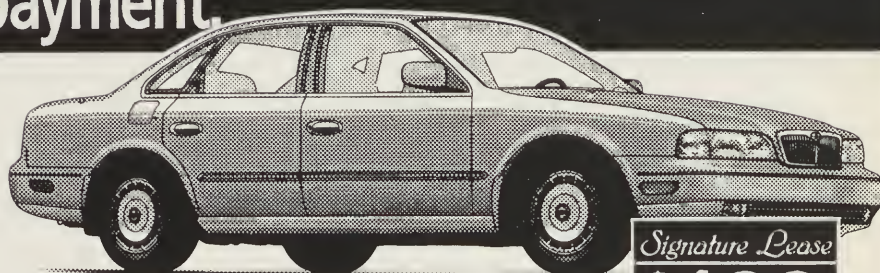
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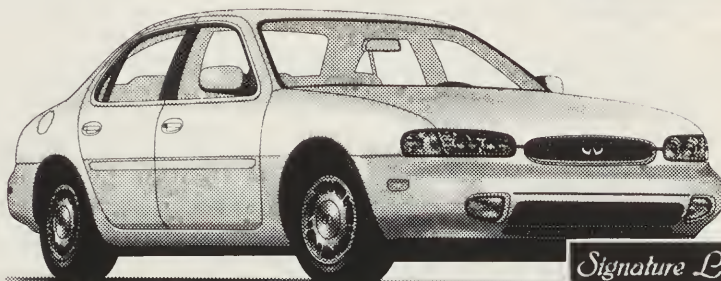
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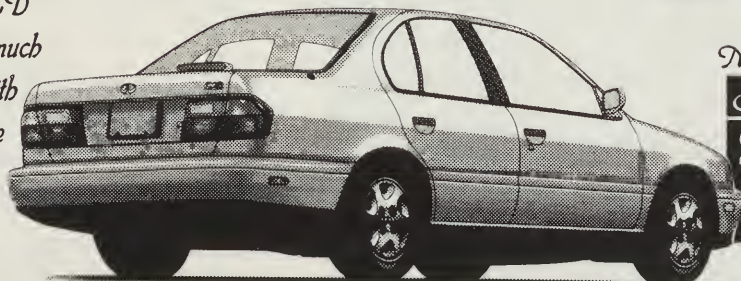
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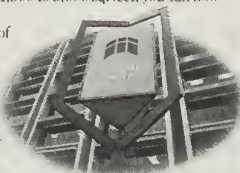
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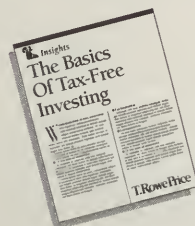
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*Free from federal, state,
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Strong Performance
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**Maryland's Tax-Free
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*Managing over
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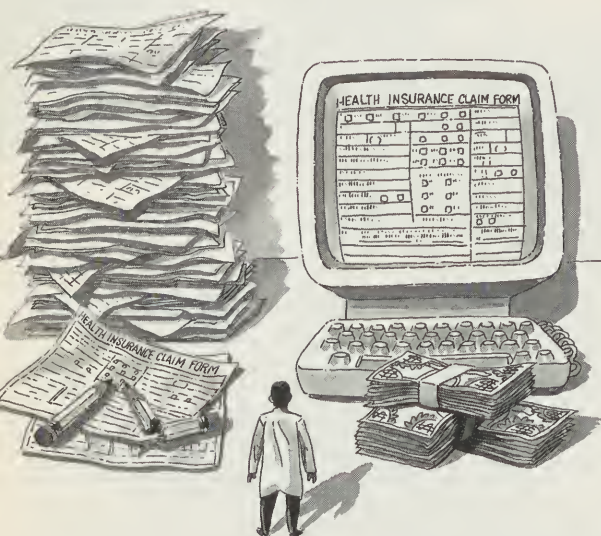
No Sales Charges
*Both Maryland bond funds
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Locally Headquartered
*Based in Baltimore
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2.8%, 8.2%, and 6.5% are the 1-year, 5-year, and since inception (3/31/87) average annual total returns, respectively, for the Maryland Tax-Free Bond Fund for the period ended 3/31/94. **2.9% and 3.8%** are the 1-year and since inception (1/29/93) average annual total returns, respectively, for the periods ended 3/31/94, for the Maryland Short-Term Tax-Free Bond Fund. Present expense limitation has increased the Maryland Short-Term Tax-Free Bond Fund's yield and total return. Figures for both funds include changes in principal value, reinvested dividends, and capital gain distributions. Total returns represent past performance and cannot guarantee future results. Investment return and principal value will vary and shares may be worth more or less at redemption than at original purchase. *Some income may be subject to state and local taxes and the federal alternative minimum tax. **Within the category of Maryland Municipal Debt Funds, the Maryland Tax-Free Bond Fund was ranked #4 out of 17 funds based on total returns by Lipper Analytical Services for the 1-year period ending 3/31/94, with the top three positions being occupied by load funds. The Fund was also ranked #3 out of seven and #2 out of five for the 5-year and since inception (3/31/87) periods ended 3/31/94, respectively. Request a prospectus with more complete information, including management fees and other charges and expenses. Read it carefully before you invest or send money. T. Rowe Price Investment Services, Inc., Distributor.

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The Raymond M. Curtis Hand Center is pleased to announce the opening of The Congenital Hand Deformities Clinic

*This clinic is staffed by Hand Specialists of
The Union Memorial Hospital.*

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*Patients are seen on the third Friday of
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*You are welcome to attend with
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For Appointments Please Call:

The UMH Hand Associates Office

The Union Memorial Hospital

Professional Building, Suite 337

201 East University Parkway

Baltimore, Maryland 21218-2895

(410) 235-5405

FAX: (410) 467-5459

New Bylaws Passed

On May 13, 1994, the Med Chi House of Delegates voted to accept new Bylaws as recommended by the Retreat Committee and as reviewed by the Bylaws Committee. The new Bylaws call for a Board of Trustees to meet on a bi-monthly basis and a House of Delegates to meet on a quarterly basis. In addition, eight councils were created: (1) bylaws, (2) ethical and judicial affairs, (3) medical education, (4) scientific affairs, (5) medical services, (6) legislation, (7) medical affairs, and (8) planning and development.

The members of the Board of Trustees (19 members) shall consist of:

- a. Med Chi Officers (president, president-elect, immediate past president and the CEO (without vote)
- b. Speaker of the House of Delegates (without vote)
- c. Vice Speaker of the House of Delegates (without vote)
- d. One trustee from each of the following: Baltimore City, Baltimore County, Prince George's County, Montgomery County, Western County Group (Allegany, Carroll, Frederick, Garrett, and Washington), Eastern County Group (Caroline, Cecil, Dorchester, Harford, Kent, Queen Anne's Somerset, Talbot, Wicomico and Worcester), Southern County Group (Anne Arundel, Calvert, Charles, Howard and St. Mary's); one member selected from the medical specialty section; three trustees at large, two of whom are selected from the Western, Eastern and Southern county groups together; and an American Medical Association delegation representative selected by the delegation. Any county whose component society shall achieve active membership of 500 physicians or more shall be entitled to representation by a single trustee and that component will not be included in the Western, Eastern or Southern county group.

The members of the House of Delegates (approximately 215 members) shall consist of:

- a. the members of the Board of Trustees (without vote);
- b. one delegate from each component society and an additional delegate for every 50 members and fraction thereof from each component society;
- c. one delegate from the section composed exclusively of student members; one delegate from the section composed entirely of active members who are on the resident staff of hospitals or hold fellowships; and one delegate (who is an active Med Chi member) from each Med Chi approved specialty society with a membership of at least 50, whose membership includes 50 percent or more members who are also members of Med Chi not to exceed 20 delegates in number;
- d. all past presidents (without vote);
- e. one alternate for each of the above with exception of trustees and past presidents; and
- f. AMA delegates (except the AMA representative on the Board of Trustees serves without vote).

Copies of the new bylaws will be available at the semiannual meeting in September. If you have any questions about the bylaws, please call Roseanne Matricciani, RN, JD, Chief Operating Officer, at 410-539-0872 or 800-492-1056 ext. 415.

***Med Chi Officers
Elected***

On May 14, 1994, the Med Chi House of Delegates elected the following officers who will serve through May 1995:

Donald H. Dembo, M.D., President (Chair, Board of Trustees)
J. Richard Lilly, M.D., President-elect (Vice Chair, Board of Trustees)
Paul A. Stagg, M.D., Secretary
Carol W. Garvey, M.D., Treasurer
Allan D. Jensen, M.D., Speaker of the House of Delegates
Louis C. Breschi, M.D., Vice-speaker of the House of Delegates
Alex Azar, M.D., Trustee
J. Ramsay Farah, M.D., Trustee
Thomas E. Allen, M.D., Trustee

Also elected were the following AMA Delegates and Alternate Delegates:

J. David Nagel, M.D., AMA Delegate
Joseph Snyder, M.D., AMA Delegate
Jose M. Yosunico, M.D., AMA Alternate Delegate
Donald H. Dembo, M.D., AMA Alternate Delegate

***Awards Presented
During 1994 Annual
Meeting***

Wyeth-Ayerst Physician Award for Community Service

Frank A. Pedreira, M.D., Montgomery County

Certificate of Recognition for Outstanding Committee Chairpersons

Ronald J. Cohen, M.D., Peer Review Management Committee
J. Ramsay Farah, M.D., HMO Quality Care and Practice Parameters TAC
Hilary O'Herlihy, M.D., Legislative Committee
Marty Wasserman, M.D., Committee on Public Health

Henry and Page Laughlin Award for Citizenship

The Honorable Louis L. Goldstein, Comptroller, State of Maryland

Henry N. Wagner, Jr., M.D., Science Award

Kevin Seivers from Baltimore, Maryland

George S. Malouf, Sr., M.D. Community Service Award

Dannah Card from Frederick, Maryland

14th Annual Med Chi Photo Contest

First Place — Alan V. Abrams, M.D.
Second Place — Michael Liteanu, M.D.

*1994 Med Chi
Semiannual Meeting*

The 1994 Med Chi Semiannual Meeting will be held Friday, September 9 through Sunday, September 11, 1994, at the Sheraton Ocean City Resort and Conference Center in Ocean City, Maryland.

Med Chi has reserved a block of rooms at a special group rate of \$114.00 per night for a single/double occupancy room (tax and incidentals not included). To reserve a room, call the Sheraton at 1-800-638-2100 and tell them you will be attending the Med Chi meeting. Please reserve early — reservation deadline is August 25, 1994, but rooms may fill prior to this date.

*Durable Medical
Equipment —Medicare*

Durable Medical Equipment (DME) claims must contain the place of service (POS) code. POS "99" is not a valid code for DME. POS codes should indicate the location where the beneficiary uses the equipment.

When an oxygen system is being rented, there is no separate allowance for oxygen conserving devices and transtracheal oxygen catheters which are considered accessories to oxygen equipment. However, if the patient is receiving covered oxygen from a purchased oxygen system, these items are separately payable.

Effective January 1, 1994, the new interest rate for Medicare clean claims not paid in a timely manner will be 5.5 percent through June 30, 1994.

Region B, the DME region for Maryland, distributes a "Region B Medicare Supplier Bulletin" to DME suppliers. Please refer to the monthly bulletins for specific details on DME coding, questions and answers, coverage of DME, and fraud and abuse alerts.

Appointment to PPRC

Donald T. Lewers, M.D., past president of Med Chi and AMA Trustee, has been appointed to the Physician Payment Review Commission (PPRC). Dr. Lewers was appointed to complete the remaining year of a term vacated by Michael McKinney, M.D. and will be eligible for a maximum of two additional three year terms on the PPRC.

*Medicare Limiting
Charge*

The limiting charge for 1994 is 115 percent of the non-par allowable for procedures that are billed unassigned. Carriers are monitoring all unassigned claims and the limiting charges submitted. Both the physician and the patient are notified of possible overcharging if the limiting charge is exceeded.

The Limiting Charge Exception Report (LCER) is sent to non-par physicians who are sending unassigned claims that exceed the limiting charge. Some LCERs require documentation to prove that an adjustment or refund of the overcharge was made. If you receive a request for documentation, please respond promptly. Although the LCER is educational, not responding and continuing to exceed the limiting charge can result in fines and sanctions.

Recall of Liquid Antibiotics

The Food and Drug Administration (FDA) has announced a recall by Eli Lilly and Company of the liquid oral antibiotics Ceclor, Lorabid and Keflex, because several containers have been found to contain a foreign object. Anyone who has found a foreign object in these projects should contact Eli Lilly at 1-800-545-5927.

If a therapeutic alternative is not readily available or appropriate, health care professionals are advised to carefully check the medicine prior to administration to ensure that it does not contain a plastic cap.

Trials and Deliberations in Medicine Seminars

Medical Mutual Liability Insurance Society of Maryland offers "Trials and Deliberations in Medicine," a seminar offering an intensive look at the medical and legal aspects of the medical malpractice process. Medical Mutual members who attend this program receive a 5% discount on their 1995 Medical Mutual renewal premium. Program fee is \$40, payable to Med*Lantic Management Services, Inc.

Upcoming seminar dates and locations:

(Registration and a light buffet are from 5:30 p.m. to 6:00 p.m. The program begins promptly at 6:00 p.m. and ends at 8:00 p.m.)

| | |
|---------|--|
| June 1 | Medical Mutual, Hunt Valley |
| June 2 | P.G. Hospital Center, Cheverly |
| June 8 | Harbor Hospital, Baltimore |
| June 14 | Medical Mutual, Hunt Valley |
| June 15 | St. Mary's Hospital, Leonardtown |
| June 16 | Med Chi, Baltimore |
| June 22 | Shady Grove Adventist Hospital, Rockville |
| June 28 | Carroll County General Hospital, Westminster |
| June 30 | Columbia Conference Center, Columbia |

Registration is required. For more information, or additional dates and locations, call Toni Davis or Natalie Harper at Medical Mutual, 410-785-0050 or 1-800-492-0193.

Mediating Medical Opinion: Strategies or Resolving Conflict

Med Chi invites you to join renowned healthcare negotiation expert, Leonard J. Marcus, Ph.D. on Wednesday, July 20, 1994, for "Mediating Medical Opinion: Strategies for Resolving Conflict," an important one-day workshop which builds the non-adversarial negotiation skills necessary for today's medical practice. This seminar, sponsored by Med Chi in association with AMA Financing & Practice Services, Inc. (a subsidiary of the American Medical Association) is being held at Med Chi, 1211 Cathedral Street, from 8:00 a.m. - 5:00 p.m.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for 7 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor

Continuing Medical Education (CME) for physicians.

Registration is \$50 for Med Chi members and \$75 for non-members. For a registration form, or additional information, call Joan Mannion at 410-539-0872 or 1-800-492-1056.

***Tomorrow's Efficiency
in Today's Medical
Practice Seminar***

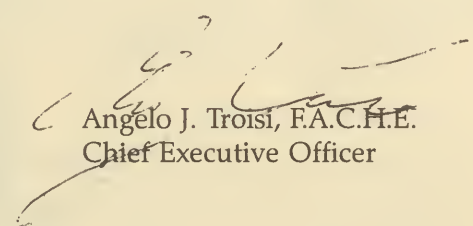
On Saturday, June 4, 1994, Med Chi and Suburban Hospital will present "Tomorrow's Efficiency in Today's Medical Practice" from 8:30 a.m. to 12:30 p.m. in the auditorium of Suburban Hospital. This conference is dedicated to improving management skills using modern technology in your practice. To register for this FREE conference, call the Suburban Hospital medical education office at 301-530-3869.

***Pennsylvania Blue
Shield Announces New
Corporate Vice
President***

Terrence E. Bowling has been selected by Pennsylvania Blue Shield as Corporate Vice President, Government Business. Mr. Bowling will be responsible for the management of all Pennsylvania Blue Shield Medicare carrier functions. Mr. Bowling's address is Pennsylvania Blue Shield, 1800 Center Street, Camp Hill, PA, 17011 and his phone number is (717)975-7276.

***American Medical
Association launches
Patient Protection Act***

On May 23, 1994, the American Medical Association (AMA) launched an unprecedented initiative to gain Congressional support of the *Patient Protection Act*, one element of the AMA's Campaign on Patient Choice and Physician Voice to give patients the information they need to make fully informed decisions about their health care insurance. The *Patient Protection Act* provides safeguards to help protect patients' interest and the physicians' role in health plans. A copy of an advertisement in support of the act, which appeared in *The Washington Post* and *Wall Street Journal*, follows this issue of the *Chief Executive Officer's Newsletter*.



Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

Med Chi would like to thank the following companies for exhibiting, or participating in the exhibit sweepstakes, at the 1994 Med Chi Annual Meeting:

| | |
|--|---|
| <i>Abbott Laboratories</i> | <i>The Med Chi Insurance Agency, Inc.</i> |
| <i>Arthritis Foundation, Maryland Chapter</i> | <i>Medical Data Resources</i> |
| <i>Bell Atlantic</i> | <i>Medical Mutual Liability Insurance Society of Maryland</i> |
| <i>CAL-VA, Inc.</i> | <i>Olsten Kimberly QualityCare</i> |
| <i>CFS/BlueCross and BlueShield of Maryland</i> | <i>Panasonic-Superior Health Products</i> |
| <i>Chesapeake Health Plan</i> | <i>Pfizer, Inc.</i> |
| <i>Control-O-Fax</i> | <i>Phoenix</i> |
| <i>Curatek Pharmaceuticals</i> | <i>Physician's Practice Digest</i> |
| <i>Episcopal Ministries to the Aging</i> | <i>The P.I.E. Mutual Insurance Company</i> |
| <i>First National Bank of Maryland</i> | <i>Practice Management Systems</i> |
| <i>Focus TELECommunications, Inc.</i> | <i>PSA Financial Center & Affiliates</i> |
| <i>Glaxo, Inc.</i> | <i>Robinwood Medical Center/Antietam Health Services</i> |
| <i>Healthcare Information Systems, Inc.</i> | <i>Sheraton Ocean City Resort and Conference Center</i> |
| <i>Hoechst-Roussell Pharmaceuticals</i> | <i>Smith Barney Shearson</i> |
| <i>I.C. System</i> | <i>SmithKline Beecham Pharmaceuticals</i> |
| <i>Lexus of Annapolis</i> | <i>Software Unlimited, Inc.</i> |
| <i>Manor Healthcare Corporation</i> | <i>System Source Learning Centers</i> |
| <i>Maryland Beef Industry Council</i> | <i>The Upjohn Company</i> |
| <i>Maryland Health Information Network</i> | <i>Statland & Katz, Ltd.</i> |
| <i>Maryland Medical Laboratory, Inc.</i> | <i>W & A Medical Related Services, Inc.</i> |
| <i>Maryland Society of Eye Physicians and Surgeons</i> | |
| <i>MBS Group</i> | |

In addition, Med Chi would like to extend a special thanks to the following sponsors for support of the 1994 Med Chi Annual Meeting:

Abbott Laboratories
The Maryland Beef Industry Council
The Med Chi Insurance Agency, Inc.
Pfizer, Inc.
Physician's Practice Digest
Ramada Inn and Convention Center
SmithKline Beecham Pharmaceuticals
The Upjohn Company

Special note to Med Chi members: Please remember exhibitors and sponsors are an integral part of the annual and semiannual meetings. Many of these companies provide on-going support by advertising in the *Maryland Medical Journal* and the Med Chi membership directory.

WHAT YOU DON'T KNOW CAN HURT YOU.



That's why Congress *must* pass the Patient Protection Act.

There are things insurance companies don't want you to know about their health plans.

That's why you need the facts. So you can make informed choices and get quality care in spite of their efforts to keep you in the dark.

The Patient Protection Act will require insurance companies to give you all the information you need *before* you join a health plan. They'll have to tell you what is and isn't covered in their plan. What sort of incentives they give to limit the care you get. What sort of approval process you have to go through to get the care you need. And how many people have dropped out of their plan because they were dissatisfied with the care they got.


It will also make sure your doctor has a say in your plan's medical policies and make it illegal for your plan to fire your doctor for giving you all the care you need. What's more, it will allow you to choose your *own* doctor – instead of having one chosen for you.

In short, the Patient Protection Act requires insurance companies to give you a full explanation of how their plan's limitations affect you. So you and your family can make an informed, intelligent decision about the one thing that's more important than any other. Your health.

This is the moment of truth. Call your senators and representative now. Demand that they support the Patient Protection Act. Because when you're dealing with the insurance industry, what you don't know really can hurt you.

American Medical Association
Physicians dedicated to the health of America





MARK YOUR CALENDAR! MED CHI' S 1994 SEMIANNUAL MEETING

Friday,
September 9, 1994
thru Sunday,
September 11, 1994
Sheraton Ocean City
Resort and Conference Center

For room reservations, call 1-800-638-2100
and tell them you will be attending the Med
Chi meeting. Please reserve early; reservation
deadline is August 25, 1994, but rooms may
fill prior to this date.

Med Chi group room rate: \$114 per night
single/double occupancy (tax and incidentals
not included).



FOR THE NASAL AND
NON-NASAL SYMPTOMS
OF SEASONAL
ALLERGIC RHINITIS

A Clear Choice In Antihistamine Therapy

- **Proven efficacy**

- **Nonsedating***

The incidence of sedation with CLARITIN Tablets (8%) was similar to that of placebo (6%) at the recommended dose.

- **Rapid-acting†**

CLARITIN Tablets started working in some patients in as soon as 30 minutes; 65% of patients experienced relief within 2 hours.¹

- **Once-a-day dosing**

- **Low incidence of adverse effects**

In controlled clinical trials using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN Tablets was similar to that of placebo (11%, 6%, 3%, and 2%, respectively).

- **Over 1 billion patient days of worldwide experience**

**Clear Benefits
From Start To Finish**

Once-a-day

Claritin[®]
10 mg (loratadine)
TABLETS

* In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes ($P=0.04$). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo ($P=0.03$).

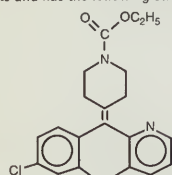
Please see following page for brief summary of Prescribing Information.

CLARITIN[®] of loratadine ETS Acting Antihistamine

PRODUCT INFORMATION

CLARITIN Tablets contain 10 mg micronized loratadine, an antihistamine, to be administered orally. They also contain the following inactive ingredients: corn starch, lactose, and magnesium stearate.

Loratadine is a white to off-white powder not soluble in water, but very soluble in acetone, alcohol, and chloroform. It has a molecular weight of 354.46 and an empirical formula of $C_{22}H_{27}ClN_2O_2$; its chemical name is ethyl 4-(6-dihydro-11H-benzo[5,6]cyclohepta[1,2-b]pyridin-11-ylidene)-4-carboxylate and has the following structural formula:



HARMACDLOGY Loratadine is a long-acting tricyclic antihistamine with peripheral histamine H_1 -receptor antagonistic activity. In human skin wheal studies following single and repeated 10 mg of CLARITIN Tablets have shown that the drug exhibits an antihistaminic effect beginning within 1 to 3 hours, reaching a maximum at 8 to 12 hours and lasting in excess of 24 hours. There was no evidence of tolerance after 28 days of dosing with CLARITIN Tablets.

In kinetic studies following single and multiple oral doses of 10-115 volunteers showed that loratadine is rapidly absorbed and metabolized to an active metabolite (descarboethoxyloratadine). The enzyme systems responsible for metabolism have not been identified. Approximately 80% of the total dose administered can be found in the urine and feces in the form of metabolic products. The mean elimination half-lives found in studies in normal subjects ($n = 54$) were 8.4 hours (range = 3 to 20 hours) for loratadine and 28 hours (range = 8.8 to 92 hours) for the major active metabolite (descarboethoxyloratadine). In nearly all patients, exposure (AUC) of loratadine is greater than exposure to parent loratadine.

Involving twelve healthy geriatric subjects (66 to 78 years old), the peak plasma levels (C_{max}) of both loratadine and descarboethoxyloratadine were significantly higher (approximately 50% increased) in the younger subjects. The mean elimination half-lives for the active metabolite were 18.2 hours (range = 6.7 to 37 hours) for loratadine and 28 hours (range = 11 to 38 hours) for the active metabolite.

Loratadine, dosed once daily, had reached steady-state by the fifth day. The pharmacokinetics of loratadine and descarboethoxyloratadine were independent over the dose range of 10 to 40 mg and are not significantly affected by the duration of treatment.

In clinical efficacy studies, CLARITIN Tablets were administered in a single-dose study, food increased the AUC of loratadine by 40% and that of descarboethoxyloratadine by approximately 15%. The peak plasma concentration (T_{max}) of loratadine and descarboethoxyloratadine was delayed by 1 hour with a meal. Although these differences were not expected to be clinically important, CLARITIN Tablets should be administered on an empty stomach.

In subjects with chronic renal impairment (Creatinine Clearance < 30 mL/min) both the AUC and peak plasma levels (C_{max}) increased on approximately 73% for loratadine; and approximately by 120% for descarboethoxyloratadine, compared to individuals with normal renal function. The mean elimination half-lives of loratadine (7.6 hours) and descarboethoxyloratadine (23.9 hours) were not significantly different from those in normal subjects. Hemodialysis does not have an effect on the pharmacokinetics of loratadine or its active metabolite (descarboethoxyloratadine) in subjects with chronic renal impairment.

In subjects with chronic alcoholic liver disease the AUC and peak plasma levels of loratadine were double while the pharmacokinetic profile of the active metabolite (descarboethoxyloratadine) was not significantly different from that in normals. The elimination half-lives for loratadine and descarboethoxyloratadine were 24 hours and 37 hours, respectively, and both increasing severity of liver disease.

There is considerable variability in the pharmacokinetic data in all studies with CLARITIN Tablets, probably due to the extensive first-pass metabolism. The pharmacokinetic data, including the area under the curve, clearance, and volume of distribution, showed a log normal distribution with a 25-fold range in distribution in healthy subjects.

Loratadine is about 97% bound to plasma proteins at the expected concentration (2.5 to 100 ng/mL) after a therapeutic dose. Loratadine does not bind to plasma protein binding of warfarin and digoxin. The metabolite (descarboethoxyloratadine) is 73% to 77% bound to plasma proteins (at 0.5 to 10 ng/mL).

In autoradiographic studies in rats and monkeys, radiolabeled loratadine studies in mice and rats, and *in vivo* radioligand studies have shown that neither loratadine nor its metabolites readily cross the blood-brain barrier. Radioligand binding studies with guinea pig pulmonary H_1 -receptors indicate that there was preferential binding to the central nervous system H_1 -receptors.

In studies of CLARITIN Tablets involved over 10,700 patients who received CLARITIN Tablets or another antihistamine and/or placebo in double-blind randomized controlled studies. In placebo-controlled trials, the daily dose of CLARITIN Tablets was superior to placebo and similar to the 1 mg BID or terfenadine (60 mg BID) in effects on nasal and ocular symptoms of allergic rhinitis. In these studies, somnolence occurred more frequently with CLARITIN Tablets than with clemastine and at a lower frequency with terfenadine or placebo. In studies with children, tablets at doses 2 to 4 times higher than the recommended dose

of 10 mg, a dose-related increase in the incidence of somnolence was observed. Therefore, some patients, particularly those with hepatic or renal impairment and the elderly, may experience somnolence.

In a study in which CLARITIN Tablets were administered at 4 times the clinical dose for 90 days, no clinically significant increase in the QTc was seen on ECGs.

INDICATIONS AND USAGE CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS **General:** Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be administered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{0-12h}/AUC_{0-12h} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS

| | PERCENT OF PATIENTS REPORTING | | | |
|------------|---|----------------------------|--|--|
| | LORATADINE 10 mg QD <i>n</i> = 1926 | PLACEBO <i>n</i> = 2545 | CLEMASTINE 1 mg BID <i>n</i> = 536 | TERFENADINE 60 mg BID <i>n</i> = 684 |
| Headache | 12 | 11 | 8 | 8 |
| Somnolence | 8 | 6 | 22 | 9 |
| Fatigue | 4 | 3 | 10 | 2 |
| Dry Mouth | 3 | 2 | 4 | 3 |

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hyposthesia, impotence, thirst, flushing.

Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.

Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.

Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System Arthralgia, myalgia.

Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.

Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.

Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.

Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.

Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema; abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis; alopecia; seizures; breast enlargement; erythema multiforme; and anaphylaxis.

DRUG ABUSE AND DEPENDENCE There is no information to indicate that abuse or dependency occurs with CLARITIN Tablets.

OVERDOSAGE Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdose, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdose would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD₅₀ values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

DOSE AND ADMINISTRATION Adults and children 12 years of age and over: One 10 mg tablet daily on an empty stomach.

In patients with liver failure, 10 mg every other day should be the starting dose.

HOW SUPPLIED CLARITIN Tablets, 10 mg, white to off-white compressed tablets; impressed with the product identification number "458" on one side; and "CLARITIN 10" on the other; high density polyethylene plastic bottles of 100 (NDC 0085-0458-03). Also available, CLARITIN Unit-of-Use packages of 14 tablets (7 tablets per blister card) (NDC 0085-0458-01) and 30 tablets (10 tablets per blister card) (NDC 0085-0458-05); and 10 x 10 tablet Unit Dose-Hospital Pack (NDC 0085-0458-04).

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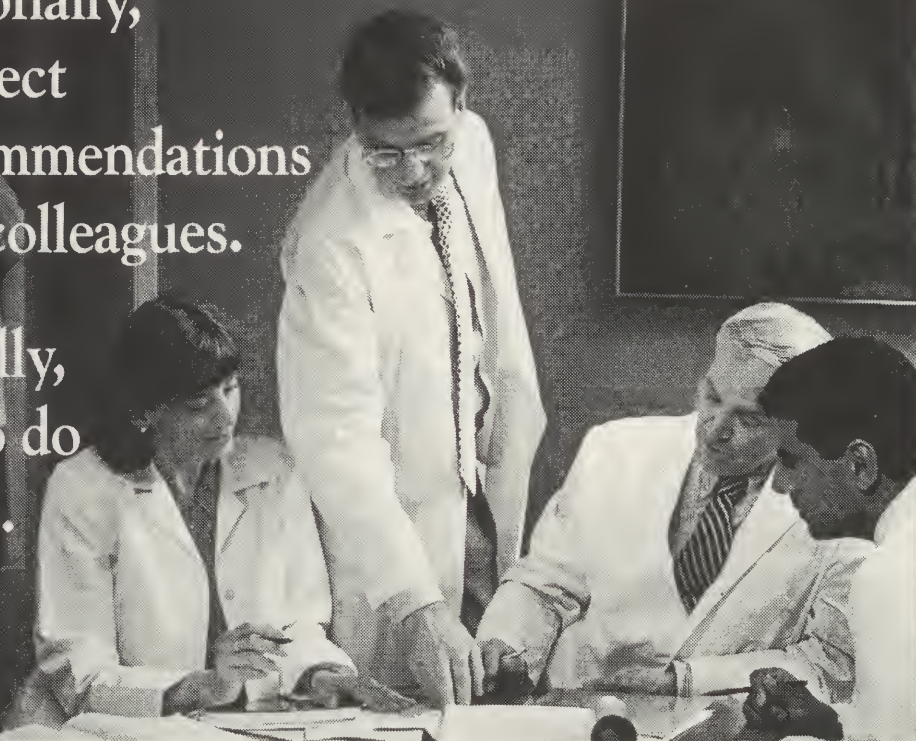
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I N T E L L I G E N T , I N D I V I D U A L I Z E D F I N A N C I N G

Speak Out

Lies, damned lies, and statistics

Decades ago I sat warily in **Logic 101**. The class was conducted by Dr. Lewis Feuer, one of the few heroes in my life. He read from a paper that had been recently published in one of the prestigious journals devoted to psychology. A research team from an eminent medical college had performed IQ tests on 100 prison inmates and compared their results with a matched group of men and women randomly culled from their community. The tests were interpreted by specialists who were blinded to the identities of those examined. The results were uniform and quite dramatic. The prisoners scored an average of 70. The control group scored an average of 110. The researchers subjected their figures to a variety of sophisticated and scholarly numerical exercises. Their conclusions were statistically significant: criminals were indisputably dumber than the rest of society.

Dr. Feuer paused a moment, then said, "Maybe it's **only the dumb ones who were caught.**"

Today we are inundated by a deluge of "scientific" papers, over 100 peer-reviewed medical journals, and innumerable throw-away publications. Thoughtful physicians routinely scrutinize these periodicals in an attempt to maintain their proficiency and knowledge. In so doing, they must understand the rationale for each study, the methods used, and the relevance of the results.

It is unfortunate that the final ingredient—the statistical evaluation—is the most vexatious. Consider the following examples taken from four distinguished medical journals which I receive routinely:

Based on an expected efficacy of 85% in the octreotide group and 90% in the sclerotherapy group...with a two-tailed test to achieve a statistical power of 80% and a 5% alpha error, we estimated that at least 900 patients in each group were needed....Data are given as mean (SE) or percentages with 95% confidence intervals (CI). Student's T test was used for continuous variables and the two-tailed Fisher's exact test for categorical variables. The non-parametric Mann-Whitney U test was used for comparison of blood transfusion and duration of hospital stay. For mortality assessment, the Kaplan-Meier method was used to construct life tables, and the non-parametric log-rank test was used to assess differences between the groups. Cox's proportional hazards model was used to evaluate relative risks for independent prognostic factors.¹

Results are generally expressed as mean \pm SD. Student's T tests were used to compare differences between pairs of groups. The

Speak Out

correlation of continuous variables was assessed by linear regression analysis. Proportional data were compared by means of chi-square analysis. The null hypothesis was rejected at a p level <0.05 .²

Multiple linear regression was used to analyze continuous outcome variables. Stratified exact tests and exact Wilcoxon tests, as well as logistic-regression methods were used to analyze categorical outcome variables.³

Continuous variables were expressed as mean \pm 1 SD, with differences assessed by the Student paired or unpaired T test. Variables with a nongaussian distribution were described with median and range or interquartile values. Paired and unpaired binomial variables were compared using the sign and Fisher chi-square significance tests, respectively. Differences between paired and unpaired ordinal categoric variables were assessed for significance by the Wilcoxon and Mann-Whitney tests, respectively. All p values ≤ 0.10 were reported; p >0.10 was designated as nonsignificant (NS). Multivariate logistic analysis was used to detect association between baseline or procedural variables and clinical outcome. Event-free survival analysis was performed by the Kaplan-Meier method, with significance testing by the Mantel log-rank test....⁴

I confess that such statistical probes are less than crystal clear to me. I therefore routinely skip that section of the paper and move quickly to the conclusions, a behavior I suspect is not foreign to other physicians. I cite this not because I disparage the importance of statistics. Nor do I fail to grasp the relevance of seeking a more objective process to define the results of a scientific experiment. I cite it simply in recognition of my ignorance concerning statistical techniques and as confirmation of my faith in the integrity of authors and their editors.

Nonetheless, we must all recognize that a statistically "significant" outcome does not guarantee the accuracy of the results. Furthermore, data that fail to achieve statistical "significance" may be quite valid. (Copernicus would have been laughed out of the astronomical community, and Edward Jenner would not have been permitted to publish his theory of vaccination based on the sole case of James Phipps.)

Relevant statistical analysis is quintessential to scientific papers. But it is so replete with arcane expressions and esoteric idiom as to be virtually incomprehensible to the average physician. I therefore suggest that all peer-reviewed **clinical** journals:

Speak Out

1. Require authors to present their **complete** original data and the statistical methods used. This should enable competent readers to confirm the information for themselves.
2. Insure that the authors' conclusions are, in fact, validated by **appropriate** calculations. This can only be accomplished by requiring that every peer-reviewed paper accepted for publication be evaluated by a competent medical statistician.

Although such changes would impose a substantial burden on some journals (e.g., the *Maryland Medical Journal*), the alternative seems unacceptable: continued reliance on the **conclusions** of medical papers without adequate assurance of their probable validity.

It may well be that only the dumb crooks were caught.

BARTON J. GERSHEN, M.D. ■

References

1. Sung JY, Chung SC, Lai CW, Chan FK, Leung JW, Yung MY, Kassianides C, Li AK. Octreotide infusion or emergency sclerotherapy for variceal hemorrhage. *Lancet* 1993; 342:637-41.
2. Sheldon RS, Wyse DG, Mitchell LB, Gillis AM, Kavanagh KM, Duff HG. Characteristics of patients with nonfatal cardiac arrest 3 to 180 days after acute myocardial infarction. *Am J Cardiol* 1993; 72:753-58.
3. Newburger JW, Jonas RA, Wernovsky G, Wypij D, Hickey PR, Kuban CK, Farrell DM, Holmes GL, Helmers SL, Constantinou J, et al. A comparison of the perioperative neurologic effects of hypothermic circulatory arrest versus low-flow cardiopulmonary bypass in infant heart surgery. *N Engl J Med* 1993; 329:1057-64.
4. Lincoff AM, Topol EJ, Chepekis AT, George BS, Candela RJ, Muller DW, Zimmerman CA, Ellis SG. Intracoronary stenting compared with conventional therapy for abrupt vessel closure complicating coronary angioplasty: A matched case-control study. *J Am Coll Cardiol* 1993; 21:866-75.

Share your opinions

The Editorial Board of the *Maryland Medical Journal* encourages Med Chi members to share their opinions, beliefs, and convictions about all aspects of medicine. Letters to the Editor and essays for *Speak Out* should be sent to Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, MD 21201-5585.

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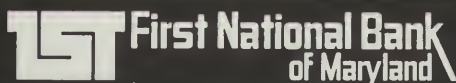
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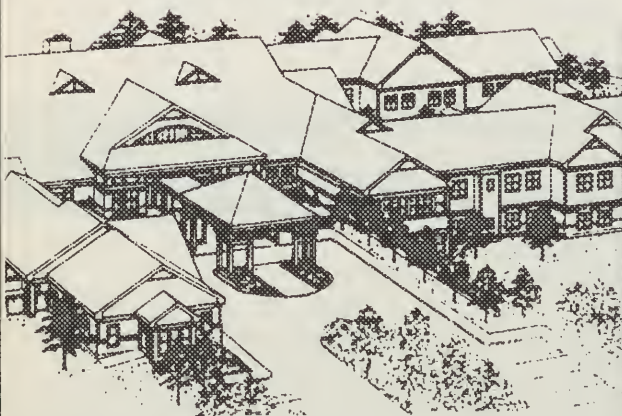
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The 28-point mini-mental status examination

Is there such a thing as a 28-point mini-mental status examination? It really does exist! Its presence depends on the type of mini-mental status examination that is being performed and possibly the "state" where it is being performed. When assessing "place" in the **Orientation** section of the examination, it does matter whether you mean "where the patient is at" but not "where the patient lives." It does not exist if the examination is being performed in other states of the United States and you live in the one in question. However, it is not related to the educational level of the person being evaluated, since we know that the mini-mental status examination should be interpreted with caution depending on educational level. Although a recent study indicates that "normal" mini-mental status examination scores tend to vary by age,¹ the presence of the 28-point mini-mental examination has no relevance to the average age of the population that lives in this "state." The lack of an answer as to how to interpret the examination may have something to do with how frequently this mini-mental status examination is performed in this particular "district" of the country since the phenomenon has never been officially ad-

dressed as far as we know. If the phenomenon has been noticed and discussed, we know of no formal method to adjust for it, and I am an academic geriatrician who has been practicing in this "state" for 18 months. It is not even related to the number of federal officials or geriatricians employed in the "state" or the number of federally operated agencies or buildings. Would you believe that the phenomenon is not related to the crime rate, the cost of living, or the number of elderly driving in this "state." The 28-point examination even became non-existent when our clinic moved about a mile to a nearby state! Does everybody give up as to which "state" or "wishful state" that we are talking about? We are open to suggestions on how to address this phenomenon.

CHARLES A. CEFALU, M.D., M.S.
Dr. Cefalu is Director of Geriatrics, Department of Family Medicine, Georgetown University School of Medicine, Washington, DC.

Reference

1. Crum RM, Anthony JC, Bassett SS, Folstein MF. Population-based norms for the Mini-Mental State Examination by age and educational level. *JAMA* 1993; 269:2386-91.

LETTERS TO THE EDITOR


The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

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Donald H. Dembo, M.D., F.A.C.P., F.A.C.C.: 1994–1995 president, Medical and Chirurgical Faculty of Maryland

Vivian Smith

Ms. Smith is the assistant director of communications for the Medical and Chirurgical Faculty of Maryland.

Terms once familiar only to health care policy analysts—managed care, fee-for-service, pay or play, single payer, preexisting condition—have become the standard vocabulary for today's physicians and many members of the general public. Incoming president, Dr. Donald H. Dembo, a practicing cardiologist, is extremely familiar with these terms, and in fact writes a column on health system reform for the *Sinai Physician*, a Sinai Hospital newsletter. He has also been on the faculty of the American Medical Association's (AMA) workshops for "Medicine in Transition: Strategies for Change." In response to the new health system climate, he has appropriately chosen communication as his theme for the coming year.

Health system reform

Dr. Dembo feels strongly that health system reform is the greatest challenge that physicians have ever faced. He identifies insurance availability and affordability, access to health care, escalating costs and practice guidelines as significant problems in health care. Dr. Dembo feels that the affordability of insurance benefits (including continued coverage when changing jobs), guaranteed basic benefits, and prohibition of underwriting (excluding allegedly poor risk patients) by small market reform are issues that must be supported by Med Chi.



Dr. Dembo and his wife, Libby, enjoy the sunshine on their recent trip to Vail, Colorado.

Dr. Dembo cites specific areas in health system reform that he feels must be addressed. He is opposed to caps on total expenditure for health care, stating, "With an aging population, increasing sophistication in health care, and unresolved societal issues it will be unlikely that price controls can work to contain costs." He also feels strongly that tort reform must continue. He fears that the "devastating decision" to exclude wrongful death from the cap on non-economic awards will have a serious impact on the cost of malpractice for years to come. He notes that the state legislature rejected considering this issue retroactively and points out that many cases are still outstanding. Malpractice awards usually include the estimated cost of lifetime health care for the injured. There may



Dr. Dembo in his office at Sinai Hospital.

be other (collateral) sources for health care in many cases. Although there is a collateral source law in Maryland, the law does not make it mandatory to use collateral sources such as health insurance to reduce the amount of malpractice awards, and there is still the issue of unbridled contingency fees that has not been addressed. Dr. Dembo points out, "If losers had to pay the legal costs of winners, there would be less litigious frenzy."

The establishment of a vast federal or state bureaucracy, with responsibilities in directing the number of specialists and primary care physicians, and deciding the where, when and how of doctors' practices, would be counterproductive, states Dr. Dembo. He feels that under such a system, individuals exhibiting special expertise or interest will not be permitted to pursue the field of their choice. He also fears that the government bureaucracy will put limitations on institutions providing specialty training. "Those very individuals who participate in specialty training through fellowships are those who provide the sophisticated, unprejudiced research for the development of new drugs and devices." Dr. Dembo finds that individual practice patterns are often responsive to drug or device representatives, rather than objective assessment of new products. He questions who we want doing this important research—someone with a fiscal interest, or someone with an interest in objective research.

To Dr. Dembo, managed competition is an oxymoron. "It does not seem realistic to consider a free market and regulation with the same breath." He feels practice parameters and algorithms for care need to be further developed and utilized, and it needs to be recognized that these suggestions are guidelines and not standards.

He feels the access issue may be exaggerated since many of the "arbitrarily determined 37,000,000 Americans who do not have access to care are individuals between jobs or those who

do not care to be insured, as well as the indigent and truly underserved." It is Dr. Dembo's view that cost containment may best be achieved by having consumers assume at least some share of the cost of their health care. With cost sharing, the use of the health care system will be reduced in minor illnesses such as the common cold. Patients will question diagnostic tests concerning their necessity when some of the cost is shared by the patient.

Dr. Dembo's biggest concern, however, is societal issues. He believes we need to address tough questions about who lives and who dies, the prolongation of useless life, the use of respirators on terminally ill patients, babies having babies, and lifestyles with substance abuse. "The government criticizes the quality of our health care using high fetal mortality rates in this country as an example, which is not a reflection of health care quality." He emphatically states that no one who is actually ill is turned away from an emergency room, immunizations are available to babies, and prenatal care is equally available. He finds the problem is that there is no interface between the availability of health care and those individuals who need it. "We must figure out how to bring individuals into the health care system. And we must look at domiciliary and nursing home care. Dr. Dembo asks, "Is rehabilitation possible so that such individuals can live in less costly environments, perhaps even home environments, with appropriate assistance?"

Dr. Dembo acknowledges that this year's legislative agenda will be a busy one. A number of bills will be revisited including patient access or the "any willing provider" bill and the bill on free-standing and diagnostic and treatment centers. There are a number of concerns about our health care law established by House Bill 1359 that have not been resolved by regulators or through legislative process, says Dr. Dembo. He acknowledges that there needs to be dialogue between the players. "We should understand the position of managed care organizations and hospitals and free-standing units, should re-examine limitations on laboratory sample acquisition and interpretation fees, and through dialogue, reach a consensus that will benefit physicians and through physicians their patients." Very important to him however is the prioritization and pursuit of issues in the public good. He points out that a significant portion of his agenda will be to address issues important from a public health standpoint, which, because of the pressure of other political, regulatory, and pocketbook issues, have been somewhat shortchanged by not being considered and in many instances not supported by Med Chi.

In Dr. Dembo's opinion the changes that are happening in medicine are largely in response to market demands. "The threat of legislation has accelerated those changes," he says, "and I am distressed that we have not been as active as we should be in engineering the process of change in Maryland."

Med Chi

Dr. Dembo feels that for many years Med Chi has "exhausted itself in the political issues of who wins and who loses." He wants to see the appointment process within Med Chi changed so that leadership positions are earned based upon a person's ability rather than given as a reward for a political favor. He feels Med Chi needs to bring in bright young minds and help them achieve the knowledge that goes into leadership. "Call upon the best minds to represent us in Annapolis and before the public," he encourages.

Dr. Dembo also stresses the need for a strong administration, "the backbone of Med Chi's strength." He points out his employment philosophy: because many individuals spend most of their waking time at work, a happy environment is likely to result in greater productivity. Dr. Dembo plans to meet with Med Chi staff on a regular basis. He also wants component society executives to meet regularly and will establish a President's Advisory Cabinet with meetings of component society presidents. Regular communication will play a major role in his year as president. Dr. Dembo notes that Jay

Schwartz, Med Chi lobbyist, has already demonstrated the value of communication with an alliance of lobbyists meeting together on a regular basis.

Our new president is quite aware of the need for issues debate, consensus, and compromise, and acknowledges that there will be differences. He acknowledges that the majority must rule. He respects the rights of individuals with strong minority opinions and encourages them to express their opinions. However, he insists that when these opinions are expressed publicly, they must be identified as a minority opinion, and not the opinion of Med Chi. He stresses, "Individuals in positions of membership responsibility have a duty to honestly represent the membership of Med Chi." He also points out the importance of Med Chi members "listening to each other and debating issues in open friendship, recognizing that in the last analysis, it is the patient for whom we must be advocates."

Dr. Dembo feels "particularly proud of the hard work performed by the retreat committee under the able leadership of Dr. Allan Jensen." He states, "Our new governance will create many challenges, but it is with optimism that we move forward with a streamlined, efficient organization and fair representation."

Background

Dr. Dembo truly loves being a physician. "It's a fantastic sense of satisfaction to be able to address misery and reverse it—not just saving lives, but changing the quality of life." But medicine was not the original career choice for Dr. Dembo. Throughout high school he planned to become an engineer. However, when he applied to college and was requested to indicate a specific engineering interest, he realized that he did not want to be an engineer at all. He designated an arts and science major on half of his applications and decided to attend the first college that accepted him, which was The Johns Hopkins University. He first seriously considered becoming a physician when he was accepted to the pre-medical program at the end of his first year. After receiving his A.B. degree from Johns Hopkins, he earned his M.D. from the University of Maryland School of Medicine.

After his third year of postgraduate training in internal medicine, he sought financial relief from his \$50 per month stipend by enlisting in the United States Army. Stationed in Frankfurt, Germany, Dr. Dembo became the assistant cardiologist for the European theater of operations purely by chance.

He returned to an American Heart Association of Maryland Affiliate research fellowship in cardiology at the University of Maryland. He subsequently was chief of cardiology at Maryland General Hospital for 31 years and while there established the first dedicated cardiac catheterization laboratory in a community hospital. Also while at Maryland General, he developed the first coronary care unit in a Baltimore hospital.



Dr. and Mrs. Dembo straddle the equator in Kenya.

and inserted the first permanent pacemaker in this area. He has also been chief of cardiology at Good Samaritan Hospital since 1976, and has been an assistant professor of medicine at the University of Maryland and is presently assistant professor of medicine at The Johns Hopkins University.

Dr. Dembo's research interests have been in pacemaker therapy and in cardiopulmonary resuscitation (CPR). He was a member of the first American Heart Committee on CPR and wrote or edited the first CPR manuals on advanced life support and the first instructor's manual. He has published some 50 articles on cardiology and other health care issues.

His major professional interest has been teaching. He is a teaching scholar in cardiology at Sinai Hospital. In the early years of cardiopulmonary resuscitation, he set up statewide CPR programs in Georgia, Kansas, and Hawaii that were sponsored by the American Heart Association. He has taught throughout the world as a cardiology education tour leader with lectures in East Africa, England, Scotland, Ireland, Spain, Portugal, France, Australia, New Zealand, Russia, and China. Behind Dr. Dembo's office chair, a wall is covered with framed certificates, degrees, and awards relating to his medical career, including American Heart Association awards, a Gold Apple Award for dedication and excellence in teaching awarded by his housestaff, and the Distinguished Physician Award from Sinai Hospital.

Dr. Dembo has served as chairperson, consultant, committee member, board member, and director to numerous organizations on a local, state, and national level. He serves on the Congressional Legislative Liaison Committee for the American College of Cardiology and is on Congressman Benjamin Cardin's Health Advisory Committee. He has been a participant in numerous Congressional briefings, including a briefing with First Lady Hillary Rodham Clinton, and has been actively involved in representing physicians to the Administration and Congress.

He has also been involved in organized medicine as a past president of the American Heart Association, Maryland Affiliate and the Maryland Society of Cardiology. He has served as an officer in the Baltimore City Medical Society and has chaired a number of Med Chi committees. He has been particularly interested in conservation and has been a chairperson of the advisory board of the Easton Waterfowl Festival, an



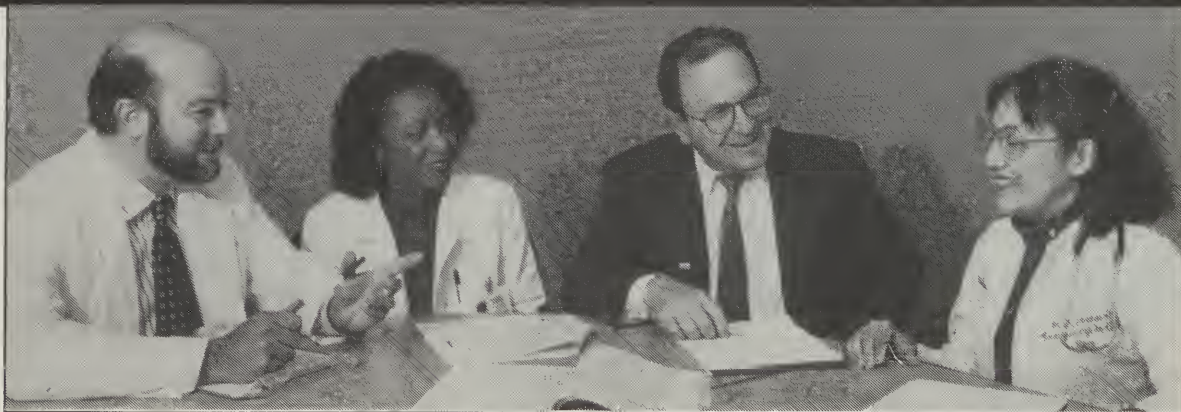
Dr. Dembo with his three grandchildren, Samantha Weinstein (left), Spencer Dembo (front), and Zachary Dembo (right).

organization devoted to the conservation and preservation of the environment.

Dr. Dembo was born and raised in Baltimore, Maryland. He has many personal interests including painting, photography, waterfowl art, boating, tennis, and writing. In the exact center of Dr. Dembo's office wall among his certificates, titles, and awards is not his most prestigious accomplishment, but rather a photograph of a small sailboat. Dr. Dembo and his family lived on this boat during vacations and some weekends, while, utilizing skills that he acquired as summer camp arts and crafts director, he, his wife and his children built—hammer and nail—their Eastern Shore home, which only took eight years to complete!

Dr. Dembo adores his family. He is very close to his children and grandchildren whose photographs adorn the furniture in his office. When he talks about his children, an unsuppressible smile spreads across his face, and he beams with pride. He jokingly says that only one of his children, Susan, "went bad: she became a lawyer." His oldest son, Steven, is in real estate finance, and his youngest son, Michael, is a corporate human relations director. He idolizes his wife of almost 42 years, Libby, to whom he refers as his lifetime best friend. The Dembos have two grandsons and one granddaughter whom they treasure and enjoy. ■

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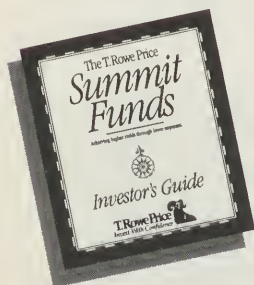
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Hypercalcemia associated with an elevated 1,25 dihydroxy vitamin D₃ level and an elevated angiotensin-converting enzyme level in a patient without evidence of sarcoidosis or malignancy

Neil S. Friedman, M.D.

Dr. Friedman is a staff oncologist at Sinai Hospital and instructor in medicine at Johns Hopkins University School of Medicine, Baltimore, Maryland.

ABSTRACT: *An 85-year-old man who presented with depression and lethargy was found to have hypercalcemia, normal phosphorous, and low-normal intact parathyroid hormone level. Work-up revealed no evidence of a malignant or inflammatory process. However, 24-hour urinary calcium excretion was increased, 1,25 dihydroxy (OH)₂ vitamin D₃ level was elevated, and angiotensin-converting enzyme (ACE) level was twice normal. The patient responded to a trial of steroids and his 1,25-OH₂ vitamin D₃ and ACE levels decreased to within normal limits. The patient has remained eucalcemic on low-dose steroids.*

After primary hyperparathyroidism, the most common cause of hypercalcemia is malignancy. The etiologies of cancer-associated hypercalcemia include direct bony involvement with local production of biologic mediators (e.g., prostaglandins, interferon, and interleukin-1) and humoral hypercalcemia of malignancy due to a parathyroid hormone (PTH)-like peptide. In a smaller number of cases, mostly lymphoid malignancies, over-production of 1,25 dihydroxy (OH)₂ vitamin D₃ has been demonstrated. A similar mechanism also has been demonstrated in granulomatous diseases associated with hypercalcemia (e.g., sarcoidosis).

No cases have been described in which hypercalcemia mediated by elevated 1,25-OH₂ vitamin D₃ occurred in the absence of an underlying pathologic process. Herein we describe one such patient.

Case presentation

The patient was an 85-year-old white male with a history of coronary artery disease for which he underwent bypass grafting five years prior to presentation. Three years prior to presentation, he had a stage A2 prostate carcinoma treated by orchiectomy. In June 1991, the patient presented with a several-week history of excessive fatigue and lethargy. He was admitted to the hospital for evaluation, where his physical examination was unrevealing.

Laboratory data: calcium, 12.8 mg/dl (3.19 mmol/L); phosphorous, 3.3 mg/dl (1.07 mmol/L); blood urea nitrogen (BUN), 44 mg/dl (15.7 mmol/L); and creatinine, 2.0 mg/dl (176 μ mol/L). A 24-hour urine collection revealed a total calcium excretion of 474 mg/24 h (11.8 mmol/d; normal = 50-300 mg/24 h, 1.2-7.4 mmol/d), although the patient was being hydrated with normal saline at the time. Thyroid function tests, serum protein electrophoresis, and urine for protein were all within normal limits. Prostate specific antigen (PSA) and serum acid phosphatase were normal. A chest radiograph showed diffuse increased interstitial lung markings and evidence of old granulomata. An intact PTH (iPTH) level was 10.72 pg/ml (normal = 10-65 pg/ml). Hydration with normal saline and diuresis with small doses of oral furosemide resulted in prompt calcium normalization.

Within six weeks, the patient's calcium was elevated again to 12.2 mg/dl (3.05 mmol/L). He was admitted to the psychiatric service for treatment of depression. Again, simple hydration with normal saline reduced the calcium to 10.8 mg/dl (2.69 mmol/L). A bone scan was normal. A computed axial tomography (CAT) scan of the abdomen showed only hepatic cysts. Prozac (fluoxetine) 20 mg/day was begun with minimal improvement of his depression.

Five weeks after discharge from the psychiatric service, the patient was seen as an outpatient and found to be lethargic. Serum calcium was 12.7 mg/dl (3.17 mmol/L). Oral etidronate 400 mg twice daily was prescribed. Two days later, the patient's symptoms had failed to improve and he was readmitted to the hospital; his serum calcium was now 12.0 mg/dl (2.99 mmol/L). Again, saline hydration and diuresis with oral furosemide brought the calcium level down to 10.7 mg/dl (2.67 mmol/L) over four days. A bone marrow biopsy and aspiration showed normal hematopoietic elements without plasmacytosis. A CAT scan of the chest was unremarkable. A 24-hour urine collection contained only 100 mg protein/24 h (0.1 g/d); a sample was sent for nephrogenous cyclic adenosine monophosphate (cAMP) and a serum sample was sent for 1,25-OH₂ vitamin D₃. From hospital days four through seven, the patient was treated with intravenous etidronate 7.5 mg/kg; calcium level stabilized at 10.7 mg/dl (2.67 mmol/L).

Laboratory results showed the 1,25-OH₂ vitamin D₃ to be elevated at 53 pg/ml (normal = 15-50 pg/ml). The 24-hour urinary nephrogenous cAMP was decreased at 0.2 mg/l (normal = 1.6-6.2 mg/l). Once this information became available, a serum sample for an angiotensin-converting enzyme (ACE) level was obtained retrospectively from the sample in which the calcium level was 12.7 mg/dl (3.17 mmol/L). ACE was found to be elevated at 123 IU/L (normal = 16-66 IU/L).

A therapeutic trial of prednisone 40 mg/day for seven days was initiated. The calcium pre-therapy level was 10.6 mg/dl (2.64 mmol/L). One week later, it was decreased to 9.7 mg/dl (2.42 mmol/L) and the 1,25-OH₂ vitamin D₃ also was decreased to 8.0 pg/ml. Prednisone dosage was reduced to 10 mg/day and the patient remained eucalcemic. Three weeks after prednisone

initiation, the ACE level also had normalized to 29 IU/L. A Venereal Disease Research Laboratories test (VDRL) was non-reactive.

Over the course of the next year, prednisone was tapered and discontinued. Approximately two months later, the patient was admitted to the hospital with rapid atrial fibrillation. His calcium level at that time was 12.2 mg/dl (3.04 mmol/L). Retreatment with steroids resulted in rapid resolution of the hypercalcemia. A serum sample taken two days after prednisone initiation revealed a normal 1,25-OH₂ vitamin D₃ level, but the ACE level was markedly elevated at 153 IU/L. Gradual reduction of prednisone dosage to 5 mg every other day maintained eucalcemia; an ACE level obtained at this dosage also was normal.

In summary, this elderly patient presented with hypercalcemia, but did not have primary hyperparathyroidism, multiple myeloma, thyroid disease, carcinoma, lymphoid malignancy, or clinical symptoms of active granulomatous disease. Work-up revealed hypercalciuria, euphosphatemia, a suppressed PTH level and nephrogenous cAMP, and a mildly elevated 1,25-OH₂ vitamin D₃ level associated with a moderately elevated ACE level. After treatment with glucocorticoids, both latter values decreased precipitously, as did the calcium. Tapering off steroids resulted in recurrent hypercalcemia associated with an elevated ACE level, both of which normalized with resumption of low-dose steroids.

Discussion

The association between hypercalcemia and sarcoidosis was first made by Harrell and Fisher in 1939.¹ This chemical abnormality is present in 10% to 20% of patients with sarcoidosis; as many as 30% to 50% have occult hypercalciuria.² Elevated levels of circulating 1,25-OH₂ vitamin D₃ were documented in an anephric patient with sarcoidosis and hypercalcemia in 1979.³ Culture of alveolar macrophages *in vitro* from a patient with sarcoidosis subsequently showed that conversion of 25-OH vitamin D₃ to 1,25-OH₂ vitamin D₃ is mediated by these cells.^{4,5} This macrophage-mediated 1-alpha hydroxylation reaction is unlike the normal renal 1-alpha hydroxylase because it is not under the usual feedback inhibition of elevated phosphorous or calcium levels (and of 1,25-OH₂ vitamin D₃); is independent of PTH; and is exquisitely sensitive to inhibition by glucocorticoids.⁶

In addition to sarcoidosis, vitamin D-mediated hypercalcemia has been implicated—although to a much lesser extent—in other granulomatous diseases, including tuberculosis,⁷ disseminated candidiasis,⁸ ruptured silicone implants,⁹ and leprosy.¹⁰

The other major causes of vitamin D-mediated hypercalcemia are lymphoproliferative disorders, specifically non-Hodgkin's and Hodgkin's lymphomas. As many as 50% of hypercalcemic patients with malignant lymphomas have either grossly or inappropriately elevated levels of 1,25-OH₂ vitamin D₃ and suppressed levels of iPTH.¹¹ In a series of patients with

Hodgkin's disease and hypercalcemia, in whom the median calcium level was 14.4 mg/dl (3.59 mmol/L), almost all levels of 1,25-OH₂ vitamin D₃ were between one and two times normal.¹² This mechanism does not appear to be responsible for the marked hypercalcemia in patients with the human T-cell lymphotropic virus type I-associated adult T-cell leukemia/lymphoma syndrome.¹³

According to most descriptions of hypercalcemia associated with sarcoidosis, clinical evidence of disease activity is not subtle. The majority of patients at least have stage I disease (hilar adenopathy). In one prospective study of calcium metabolism in patients with sarcoidosis, all patients had at least stage I disease; 18% were hypercalcemic and 62% were hypercalciuric.¹⁴ Although serum 1,25-OH₂ vitamin D₃ levels did not correlate with clinical staging, there was a slight correlation between serum ACE levels, disease activity, and hypercalciuria.

ACE is a kinin-type enzyme resident in pulmonary macrophages and endothelial surfaces. Its normal function is to convert angiotensin I into the potent vasoconstrictor angiotensin II. The most common cause for an elevated ACE level is sarcoidosis. Elevated ACE levels generally correlate with disease activity as seen on a chest radiograph, lung gallium-67 scan, or other indicators of disease activity such as lymphocytosis, hypergammaglobulinemia, and hypercalcemia.¹⁵ In one report of 14 patients with hypercalcemia and sarcoidosis, 13 had elevated ACE levels.¹⁶ Ten had stage III findings (interstitial lung disease/pulmonary infiltrates without hilar adenopathy) on chest radiograph and four had stage II findings (hilar adenopathy with pulmonary infiltration). There has been only one case report of a patient with hypercalcemia of unknown origin associated with an elevated ACE level; the patient subsequently was found to have sarcoidosis of the liver and kidney.¹⁷ One group of investigators¹⁸ does recommend ACE level evaluation in patients with "unexplained hypercalcemia" because there may be occult sarcoidosis. In most of their reported cases, however, there was some prior history of sarcoidosis. ACE also can be elevated in other diseases, such as hyperthyroidism,¹⁹ diabetes mellitus,²⁰ Gaucher's disease,²¹ berylliosis, asbestosis, and silicosis.²²

Our patient was quite old to be presenting for the first time with sarcoidosis. He had neither a past history of sarcoidosis nor pulmonary, rheumatologic, dermatologic, neurologic, or ophthalmologic manifestations of sarcoidosis. He also had no history of environmental exposure to asbestos, beryllium, or silicone. His chest x-ray did show evidence of old granulomata and increased interstitial markings, which may be consistent with past subclinical sarcoidosis. Nonetheless, he had hypercalcemia mediated by an excess production of 1,25-OH₂ vitamin D₃ in conjunction with an elevated ACE level, which is suggestive of a granulomatous/sarcoidosis-mediated process; and he was exquisitely sensitive to low doses of steroids.

This case illustrates that vitamin D-mediated hypercalcemia may be present in patients without overt manifestations of

sarcoidosis or other granulomatous diseases. An ACE level and 1,25-OH₂ vitamin D₃ level may be very helpful in guiding therapy in patients with unexplained hypercalcemia.

References

- Harrell GT, Fisher S. Blood chemical changes in Boeck's sarcoid with particular reference to protein, calcium and phosphatase values. *J Clin Invest* 1939; 18:687.
- Studdy PR, Bird R, Neville E, James DG. Biochemical findings in sarcoidosis. *J Clin Pathol* 1980; 33:528-33.
- Bell NH, Stern PH, Pantzer E, Sinha TK, DeLuca HF. Evidence that increased circulating 1 alpha 25-dihydroxy-vitamin D is the probable cause for abnormal calcium metabolism in sarcoidosis. *J Clin Invest* 1979; 64:218-25.
- Adams JS, Sharma OP, Gacad MA, Singer FR. Metabolism of 25-hydroxyvitamin D₃ by cultured alveolar macrophages in sarcoidosis. *J Clin Invest* 1983; 72:1856-60.
- Adams JS, Singer FR, Gacad MA et al. Isolation and structural identification of 1,25-dihydroxyvitamin D₃ produced by cultured alveolar macrophages in sarcoidosis. *J Clin Endocrinol Metab* 1985; 60:960-66.
- Adams JS. Vitamin D metabolite-mediated hypercalcemia. *Endocrinol Metab Clin North Am* 1989; 18:765-78.
- Gkonos PJ, London R, Hendler ED. Hypercalcemia and elevated 1,25-dihydroxyvitamin D levels in a patient with end-stage renal disease and active tuberculosis. *N Engl J Med* 1984; 311:1683-85.
- Kantarjian HM, Saad MF, Estey EH, Sellin RV, Samaan NA. Hypercalcemia in disseminated candidiasis. *Am J Med* 1983; 74:721-24.
- Kozeny GA, Barbato AL, Bansal VK, Vertuno LL, Hano JE. Hypercalcemia associated with silicone-induced granulomas. *N Engl J Med* 1984; 311:1103-05.
- Ryzen E, Rea TH, Singer FR. Hypercalcemia and abnormal 1,25-dihydroxyvitamin D concentrations in leprosy. *Am J Med* 1988; 84:325-29.
- Adams JS, Fernandez M, Gacad MA, Gill PS, Endres DB, Rasheed S, Singer FR. Vitamin D metabolite mediated hypercalcemia and hypercalciuria in patients with AIDS- and non-AIDS-associated lymphoma. *Blood* 1989; 73:235-39.
- Seymour JF, Gagel RF. Calcitriol: The major humoral mediator of hypercalcemia in Hodgkin's disease and non-Hodgkin's lymphomas. *Blood* 1993; 82:1383-94.
- Dodd CD, Winkler CF, Williams ME, Bunn PA, Gray K. Calcitriol levels in hypercalcemic patients with adult T-cell lymphoma. *Arch Intern Med* 1986; 146:1971-72.
- Meyrier A, Valeyre D, Bouillon R, Paillard F, Battesti JP, Georges R. Resorptive versus absorptive hypercalciuria in sarcoidosis: Correlations with 25-hydroxyvitamin D₃ and 1,25-dihydroxyvitamin D₃ and parameters of disease activity. *Q J Med* 1985; 54:269-81.
- Beneteau-Bernat B, Baudin B. Angiotensin-converting enzyme I. Clinical applications and laboratory investigations on serum and other biological fluids. *CRC Crit Rev Clin Lab Sci* 1991; 28:337-56.
- DeRemee RA, Lufkin EG, Rohrbach MS. Serum angiotensin-converting enzyme activity. Its use in the evaluation and management of hypercalcemia associated with sarcoidosis. *Arch Intern Med* 1985; 145:677-79.
- Leidig P, Baum HP, Krakamp B, Finke K, Bonner G. Angiotensin-converting-enzyme und 1,25-dihydroxy vitamin D₃ bei

unklarer hypercalcemie. *Dtsch Med Wochenschr* 1988; 113:2003-2006.

18. Lufkin EG, DeRemee RA, Rohrbach MS. The predictive value of the serum angiotensin-converting enzyme activity in the differential diagnosis of hypercalcemia. *Mayo Clin Proc* 1983; 58:447-51.
19. Yotsumoto H, Imai Y, Kuzya N, Uchimura H, Matsuzaki F. Increased levels of serum angiotensin-converting enzyme activity in hyperthyroidism. *Ann Intern Med* 1982; 96:326-28.
20. Lieberman J, Sastre A. Serum angiotensin-converting enzyme: Elevations in diabetes mellitus. *Ann Intern Med* 1980; 93:825-26.
21. Lieberman J, Beutler E. Elevation of serum angiotensin-converting enzyme in Gaucher's disease. *N Engl J Med* 1976; 294:1442-44.
22. Allen RKA. A review of angiotensin-converting enzyme in health and disease. *Sarcoidosis* 1991; 8:95-100. ■

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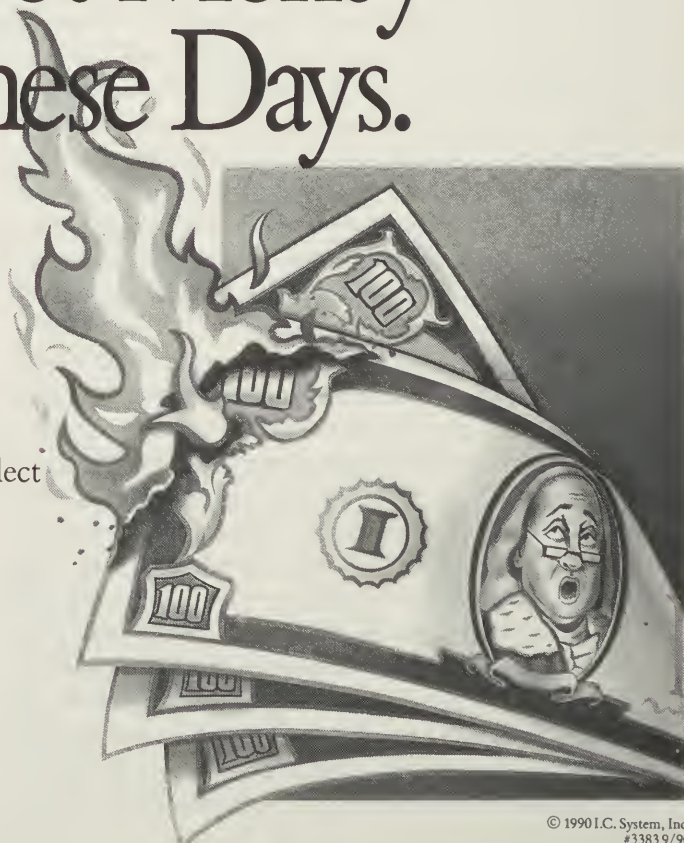
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Is routine fecal occult blood testing worthwhile in hospitalized patients?

Nwandu Anthea, M.D., Muneer Afroze, M.D., and Williams Richard, M.D.

Drs. Anthea and Afroze are senior residents, and Dr. Richard is program director at Harbor Hospital Center, Baltimore, Maryland.

ABSTRACT: *As with other forms of cancer, early detection of colorectal cancer is associated with higher survival rates. Published reports indicate that 5% to 10% of positive fecal occult blood tests (FOBT) are due to cancer. This article describes a chart review study of 23 hospitalized patients with positive FOBT results, of whom seven (30.3%) had colorectal neoplasia. Rectal examination with FOBT is recommended as part of the hospital admission examination.*

Colorectal cancer is the second most common cause of noncutaneous malignancy death in the United States,¹ with a mortality rate approaching 60%.² Improved survival is dependent on primary and secondary prevention. Primary prevention is aimed at identifying and eradicating etiologic factors that at the present time are still being elucidated. Secondary prevention, on the other hand, involves detecting pre-malignant lesions and cancer while they are still in a curable stage.

The five-year survival rate in patients with colorectal adenocarcinoma confined to the mucosa (Dukes classification A) is over 90%. In those with cancer into or through the muscularis mucosae (Dukes B), it is 70% to 85%. In those with cancer limited to or through the bowel wall with nodal metastases (Dukes C), it is 30% to 60%. In those with distant metastases (Dukes D), the five-year survival rate drops to less than 5%.³

Fecal occult blood testing (FOBT) was proposed over a century ago as a means of screening for colorectal cancer,⁴ but little attention was given to the concept until the late 1960s, when a modified technique was reintroduced. With samples collected under carefully controlled conditions in an asymptomatic population, the predictive value of a positive FOBT has been reported to be approximately 50% for colorectal neoplasia, mostly adenomatous polyps measuring 1 cm or less.²

In the uncontrolled setting of hospitalized patients, the predictive value of a positive stool for occult blood is unclear. Because house officers in our

Table 1. Conditions found in 23 patients with positive fecal occult blood testing

| Condition | Number of patients | (percent) |
|----------------------------------|--------------------|-----------|
| colorectal carcinoma | 6 | (26%) |
| colonic adenomatous polyps | 1 | (4.3%) |
| benign gastric polyp | 1 | (4.3%) |
| diverticulosis | 4 | (17.4%) |
| internal hemorrhoids | 2 | (8.7%) |
| fecal impaction | 1 | (4.3%) |
| nonspecific inflammatory changes | 3 | (13%) |
| gastritis and duodenal ulcer | 2 | (8.7%) |
| no pathology found | 3 | (13%) |

program routinely perform FOBT on stools obtained on admission digital rectal examination (DRE), we conducted a chart review study to attempt to determine the significance of a positive test.

Method

From admissions during the last six months of 1992, 100 patients were identified who had a positive FOBT on admission DRE or a positive FOBT from the laboratory. Patients were excluded if they had a history of gastrointestinal (GI) bleeding, known colorectal cancer, or use of nonsteroidal antiinflammatory agents (NSAIDs). Also excluded were patients who were not evaluated for the source of the positive FOBT.

Results

Of the 100 patients initially reviewed, 23 met inclusion criteria. Their diagnoses are shown in **Table 1**. Of the six patients with colorectal cancer, half were identified at an early stage. Their demographics and carcinoma staging are shown in **Table 2**.

Discussion

The value of a positive FOBT at the time of DRE is disputed. The American Cancer Society recommends a yearly DRE for

patients over age 40, and FOBT and sigmoidoscopy every three to five years for patients over age 50.⁵ Clinical interpretation of FOBT requires appreciation of both its benefits and limitations. FOBT is safe, inexpensive, easy to use, and readily available. In published screening trials, about 3-20 colorectal cancers are identified for every 10,000 asymptomatic people screened, but only 5% to 10% of positive FOBTs are due to cancer.⁶ Based on large studies, the sensitivity is less than 50% for cancer and much lower for adenomas.⁷ On the other hand, the specificity for colorectal neoplasia is about 35%. Factors known to influence negative outcome and interpretation of FOBT include intermittent bleeding, dehydration of the slide, low-fiber diet, ascorbic acid and antacids, polyps < 2 cm, and defects in the test kit or solution. Factors that affect positive outcome and interpretation include high peroxidase foods, rare red meats, iron supplements, aspirin or NSAIDs, nonneoplastic source of bleeding hemorrhoids, angiodysplasia, diverticulosis, and rehydrated slides.⁷

In our study population, there was an extremely high rate (7 of 23; 30.3%) of colorectal neoplasia. In contrast to the large population screening studies, most lesions in our study were carcinomas rather than adenomas. A high percentage (50%) of the colorectal cancers were at an early stage. Some of these patients did have symptoms (abdominal pain) or signs (microcytic anemia) that might have led to evaluation of the GI tract. The positive FOBT in our study population pointed to the need for further evaluation of the GI tract, potentially leading to earlier diagnosis and decreased length of hospital stay. A large number of patients with positive FOBT, however, did not receive further evaluations by their primary care physicians. Our results suggest that a significant number of these patients might have curable colorectal cancer. Although based on a limited number of patients, our data indicate that a rectal examination with FOBT should remain an important part of the admission physical examination in hospitalized patients.

References

1. American Cancer Society. *Cancer Facts and Figures*. American Cancer Society, 1986.
2. Winawer SJ, Fleisher M, Baldwin M, Sherlock P. Current

Table 2. Demographics and staging of colorectal carcinoma

| Age | Sex | Presenting symptom | HCT %* | MCV fL** | Diagnostic Procedure | Stage |
|-----|-----|--------------------|--------|----------|----------------------|---------|
| 72 | f | weakness | 29 | 82 | colonoscopy | Dukes B |
| 82 | m | abdominal pain | 31 | 92 | colonoscopy | Dukes D |
| 62 | f | hyperglycemia | 32 | 73 | colonoscopy | Dukes B |
| 76 | m | epigastric pain | 30.9 | 81 | colonoscopy | Dukes A |
| 71 | f | chest pain | 25 | 75 | barium enema | Dukes D |
| 66 | f | fever | 28 | 86 | sigmoidoscopy | Dukes D |

* hematocrit

** mean corpuscular volume

status of fecal occult blood testing in screening for colorectal cancer. *CA: Cancer J Clin* 1982; 32:100-112.

3. Mayer RJ. *Harrison's Principles of Internal Medicine*, 12th edition. New York: McGraw-Hill, Inc. 1991; 1291-92.
4. Eisner MS, Lewis JH. Diagnostic yield of a positive fecal occult blood test found on digital rectal examination. Does the finger count? *Arch Intern Med* 1991; 151:2180-84.
5. Knight KK, Fielding JE, Battista RN. U.S. Preventive Services Task Force. Occult blood screening for colorectal cancer. *JAMA* 1989; 261:586-93.
6. Simon JB. Occult blood screening for colorectal carcinoma: A critical review. *Gastroenterology* 1985; 88:820-37.
7. Goosenburg EB, Bralow SP. How to use fecal occult blood testing. *Intern Med* 1992; 13:28-31. ■

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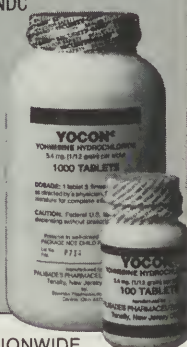
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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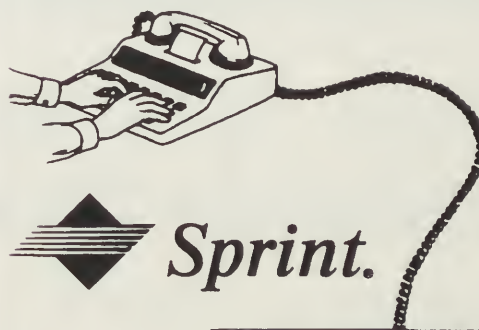
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Maryland physicians' survey on Lyme disease

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ABSTRACT: *In a survey of 252 physicians practicing in Maryland, 170 responders diagnosed 142 cases of Lyme disease (LB) during 1990 and 1991. About 80% of the cases were diagnosed by primary care physicians. The most common clinical finding, erythema migrans (EM), was reported in half the cases and arthritis was reported in a quarter. Only 22.2% had a history of a tick bite; serological tests were ordered in a third of the cases. EM was treated with oral antibiotics for 10-21 days. Most physicians treated Lyme arthritis with the same therapy although some used intravenous ceftriaxone. The most commonly used treatment for neurologic or cardiac complication was intravenous ceftriaxone. These preliminary data suggest that LB may be diagnosed by Maryland physicians more frequently than syphilis and tuberculosis. The data also indicate LB is a much larger problem in Maryland than suggested by official reports to the Centers for Disease Control. The clinical characteristics of the illness and the antibiotics prescribed for it in Maryland are similar to those reported in northeastern states.*

Lyme borreliosis (LB), caused by *Borrelia burgdorferi* and transmitted by *Ixodes dammini*, is the most common tick-borne illness reported in the United States, accounting for more than 90% of all reported vector-borne illnesses.¹ Clinical syndromes of LB vary from an acute rash, erythema migrans (EM), with or without flu-like symptoms, to late manifestation causing serious disabilities. These complications usually involve the musculoskeletal, nervous, or cardiovascular systems.²

From 1982 through 1991, cases of LB reported to the Centers for Disease Control (CDC) increased nearly 20-fold nationwide and doubled each year through 1989. Since 1990, the annual number of reported cases has reached a plateau in the range of 9,000 to 9,500.¹ Nevertheless, LB is spreading

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geographically and increasing in incidence in some areas. Although LB has been reported voluntarily by physicians in Maryland since 1982, it was not made a reportable disease in the state until 1989. The annual incidence reported in Maryland doubled each year until 1990.^{3,4} Since 1991, the number of reported cases meeting CDC criteria for LB has fallen, implying that the infection has peaked in Maryland as well.³ An alternate hypothesis is that case reporting has become less complete. We therefore conducted a survey to investigate the completeness of LB reporting in Maryland. We also asked for information about LB characteristics and the antibiotic therapy prescribed by reporting physicians to obtain baseline information and to ascertain if LB and therapeutic choices by Maryland physicians are similar to those in the northeastern states where LB has been endemic for more than 15 years.

Methods

A short questionnaire was developed regarding the number of cases of LB diagnosed by the physician during 1990 and 1991; some clinical characteristics of the cases; and the antibiotics prescribed for the different LB stages. The survey sample was selected from a computer-generated list of physicians licensed to practice in Maryland in October, 1991. On every fifth sheet, beginning with the upper left-hand corner and working vertically, the first physician was chosen who: a) practiced in a primary care field or speciality in which LB is likely to be encountered (adolescent medicine, cardiology, dermatology, family practice, general practice, internal medicine, neurology, pediatrics, and rheumatology); and b) was listed in the Medical and Chirurgical Faculty of Maryland directory or in the local yellow pages. The final sample was composed of 252 physicians to whom questionnaires were mailed accompanied by a cover letter describing the purpose of the survey. After three weeks, a second mailing with a different cover letter was sent to those who did not respond to the original mailing. Follow-up telephone calls were made to all nonresponders three weeks after the second mailing. Data were

analyzed in the form frequencies and cross tabulations using Epi Info version 5.0.

Results

Number of reported cases. Of the 252 physicians surveyed, 185 (73.4%) returned the questionnaire. Of these, 15 were retired or for other reasons did not see patients in the state during the survey period. Of the remaining 170 physicians, 48 (28.2%) reported making at least one LB diagnosis in 1990, and 38 (22.4%) reported at least one diagnosis in 1991. The total number of diagnosed cases was 144: 76 in 1990, and 68 in the first nine months of 1991. **Table 1** shows the clinical characteristics of these 144 cases. The majority of cases, 113 (78.5%), were diagnosed by primary care physicians. Of the remaining 31 cases, 20 were diagnosed by neurologists, 8 by dermatologists, 2 by cardiologists, and 1 by a rheumatologist. Survey responders also reported diagnosing 71 cases of syphilis and 108 cases of tuberculosis during the 21-month survey period.

The list of physicians who reported cases of LB to the Department of Health and Mental Hygiene (SDH) was compared with their survey responses. Eight physicians reported the same number of cases (nine) on the survey and to SDH. Reports from individual physicians, however, varied. Only two physicians reported the same results in both (one case of LB each). Three physicians reported two cases to the SDH and only one case in the survey. Another reported one case to the SDH and two cases in the survey. Two physicians reported no cases to the SDH, but reported one case each in the survey. These data show that physician reporting to the SDH and in the survey was imprecise and confirm that LB was grossly underreported in 1990 and 1991.

Characteristics of reported cases. In 75 cases (52.1%), physicians reported a rash compatible with erythema migrans (EM). Of the 75, 49 (66.2%) had a rash without other symptoms. Thirty-five (24.3%) had arthritis, of which 15 (42.9%) had arthritis only. In 17 cases (11.8%) there were other symptoms, including encephalopathy, Bell's palsy, 6th cranial nerve palsy, optic neuropathy, peripheral neuropathy, headaches, changed mental status, heart block, and generalized weakness; four of these patients were believed to have LB without a rash or arthritis. Thirty-two (18.8%) physicians considered history of tick bite a major diagnostic determinant; one made the diagnosis and selected treatment based only on a history of tick bite.

Treatment of reported cases. **Table 2** shows the frequency and ranges of treatment for EM, arthritis, and other complications as prescribed in 88 circumstances. Doxycycline was the most

Table 1. Clinical characteristics of 144 cases of Lyme disease diagnosed by 170 physicians in Maryland, 1990-1991

| Finding | Number | Percent |
|----------------------------|--------|---------|
| Erythema migrans | 75 | 52.1 |
| Erythema migrans only | 49 | 34.0 |
| Arthritis | 35 | 24.3 |
| Arthritis only | 15 | 10.4 |
| Tick bite | 32 | 22.2 |
| Tick bite only | 1 | 0.7 |
| Other symptoms & signs | 17 | 11.8 |
| Other symptoms only | 4 | 2.8 |
| Serological test performed | 48 | 33.3 |

frequently prescribed treatment for both EM and arthritis. For other LB symptoms, intravenous ceftriaxone was the most common treatment; it was also the second most common treatment for arthritis.

Discussion

Of the LB cases reported to the SDH during the past three years, about 60% to 70% met the CDC criteria.¹ During the past four years, approximately 225 cases per year have met these criteria (238 in 1990, 274 in 1991, 192 in 1992, and about 190 in 1993).³ At the time of the interview, 14,741 physicians registered to practice medicine were living Maryland. We believe LB is severely underreported in the state, since the 170 survey responders reported seeing about 80 patients with LB per year in 1990 and 1991. In addition, they reported diagnosing twice as many cases of LB than syphilis and one-third more cases of LB than tuberculosis, two reemerging infectious diseases that have a higher reported annual incidence than LB in Maryland and the United States as a whole. The actual amount of underreporting cannot be calculated, however, because the sampling method did not provide a valid random sample and the questionnaire was imprecise. Many of the 67

nonresponding physicians may not have been practicing in the state, and therefore, did not see patients with LB. Nevertheless, our crude calculations suggest that the underreporting exceeds 6-fold.

In Connecticut during 1991 and 1992, primary care physicians diagnosed 81% of 2,952 reported LB cases,⁵ which is similar to our findings (78.5%). It is noteworthy that dermatologists, who would be expected to see patients with EM, reported only 0.8% of LB cases in Connecticut⁵ and 5.5% in our survey. Rheumatologists, who would be expected to see patients with the most common complication (arthritis), reported less than 2.0% of LB cases in Connecticut⁵ and only 0.7% in our survey. A high percentage of LB cases (13.9%) were reported by neurologists in our survey; this finding is probably due to sampling bias.

LB manifests itself through a variety of symptoms. Our results indicate that, as elsewhere,² EM is the most common presenting finding in Maryland; arthritis was the most com-

Table 2. Treatment chosen by Maryland physicians for different stages of Lyme disease

| Syndrome treatment | Number | Dose (mg)* | Frequency (per day) | Duration (range) | Route |
|-----------------------|--------|-----------------|---------------------|------------------|-------|
| ◆ Erythema migrans | | | | | |
| doxycycline | 19 | 100 | 2 | 14 (10-30) | PO |
| tetracycline | 9 | 500 (250-500) | 4 | 14 (10-21) | PO |
| amoxicillin | 9 | 500 | 4 | 14 (10-30) | PO |
| penicillin | 4 | 500 (250-500) | 4 | 10 | PO |
| ceftriaxone | 4 | 1000 (500-2000) | 2 (1-2) | 14 (10-21) | IV |
| erythromycin | 2 | 250 | 4 | 14 | PO |
| Total | 47 | | | | |
| ◆ Arthritis | | | | | |
| doxycycline | 9 | 100 | 2 | 21 (21-42) | PO |
| tetracycline | 3 | 500 | 4 | 14 (10-21) | PO |
| ceftriaxone | 7 | 1000 (500-2000) | 1, 2 | 14 (10-14) | IV |
| amoxicillin | 3 | 500 (250-500) | 4 | 21 (14-60) | PO |
| erythromycin | 2 | 250, 500 | 4 | 21, 42 | PO |
| Total | 24 | | | | |
| ◆ Other complications | | | | | |
| ceftriaxone | 10 | 1000 (500-2000) | 2 (1-2) | 14 (10-56) | IV |
| doxycycline | 2 | 100 | 2 | 14, 30 | PO |
| tetracycline | 2 | 500 | 4 | 30 | PO |
| penicillin | 2 | 500 | 4 | 14 | PO |
| dicloxacillin | 1 | 200 | 3 | 21 | PO |
| Total | 17 | | | | |

* Median and (range); doses are those for adult patients.

mon symptom in chronic cases. Neurologic, cardiac, and other symptoms were less common.

Only about 20% of survey responders indicated tick bites as a determinant of LB diagnosis; 30% said they routinely gave prophylaxis for tick bites. Because of the minute size of the vectors—which frequently are not noticed and, even when found on skin or clothing, often do not infect the host—tick bite prophylaxis has not been recommended in areas where LB transmission is greater than in Maryland.⁶

The most frequently prescribed treatment for EM used by survey responders, doxycycline 100 mg twice daily for 14 days, follows published treatment guidelines.^{7,8} The most frequent treatment prescribed for arthritis was oral doxycycline 100 mg twice daily for 21 days. Intravenous ceftriaxone 1 g once or twice daily, the most commonly used treatment for other LB complications and the second most frequent regimen for arthritis, also follows current recommendations.^{7,8} The efficacy of the presently recommended antibiotic regimens to cure and

prevent the complications of LB remains uncertain; ongoing studies currently are investigating this very important question.

References

- Centers for Disease Control. Lyme disease—United States, 1991-1992. *MMWR Morb Mortal Wkly Rep* 1993; 42:345-48.
- Steere AC. Lyme disease. *N Engl J Med* 1989; 321:586-96.
- Mitchell CS, Cloren M, Israel E, Lazar C, Schwartz BS. Lyme disease in Maryland: 1987-1990. *Md Med J* 1992; 140:391-96.
- Epidemiology and disease control newsletter. Treatment of Lyme disease. *Md Med J* 1993; 42:424-26.
- Centers for Disease Control. Physician reporting of Lyme disease—Connecticut, 1991-1992. *MMWR Morb Mortal Wkly Rep* 1993; 42:348-50.
- Costello CM, Steere AC, Pinkerton RE, Feder HM. A prospective study of tick bites in an endemic area for Lyme disease. *J Infect Dis* 1992;159: 136-39.
- Rahn DW, Malawista SE. Lyme disease: Recommendations for diagnosis and treatment. *Ann Intern Med* 1991; 114:472-81.
- Anonymous. Treatment of Lyme disease. *Medical Letter* 1992; 34:95-97.

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commendation

(kām-an-'dā-shān)1: the act of commending; recommendation; praise: to earn commendation for a job well done 2: to recommend as worthy of confidence.

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The adverse effects of cholesterol in progressive glomerular injury

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ABSTRACT: *Accumulating experimental evidence indicates that hypercholesterolemia is an aggravating factor in the progression of initial glomerular injury to glomerulosclerosis. Many features of progressive glomerular disease share biological properties with atherosclerosis and emerging data suggest a noxious role for oxidized low density lipoprotein in the glomerulosclerosis process. This article reviews these issues and examines the pathobiology of cholesterol-induced glomerular injury.*

Proteinuria, hypoalbuminemia, edema, and hyperlipidemia are the four major features of the nephrotic syndrome. The hyperlipidemia that accompanies glomerular disease represents a complex pathophysiologic "adjustment" in which increased hepatic synthesis of lipoproteins without a comparable increase in lipoprotein catabolism produces the resultant metabolic derangement.¹

Much attention has been directed recently toward the secondary hypercholesterolemia of nephrosis as a putative aggravating factor in the progression of glomerular injury to glomerulosclerosis. Although some clinical studies support the pathogenetic explanations derived from the experimental animal, at present there is insufficient clinical evidence to support this hypothesis. This article therefore reviews supporting experimental data and presents recent information identifying potential roles for oxidized low density lipoprotein (LDL) and the glomerular macrophage as effector mechanisms that mediate the aggravating effect of hypercholesterolemia on progressive glomerular injury.

Cholesterol feeding and glomerular injury

Patients with the rare genetic disorder lecithin-cholesterol-acyltransferase (LCAT) deficiency demonstrate that lipid abnormalities can be associated with proteinuria.² Numerous experimental studies have demonstrated the

deleterious effects of dietary cholesterol supplementation on glomerular pathophysiology and morphology. In normal laboratory rats fed diets supplemented with 3% cholesterol or 3% cholic acid and taurine for two to 80 weeks, significant hypercholesterolemia developed within four weeks; it was accompanied by significant morphologic changes in the aorta and kidney of rats ages 1 year and older. Raised intimal plaques in the aorta were composed of large mononuclear cells with varying degrees of necrosis and calcification; in the kidney, the abnormalities were localized primarily in the glomeruli and consisted of sudanophilic droplets, hyalinosis, and segmental and/or global glomerulosclerosis.³ In uninephrectomized rats fed a cholesterol supplement over 25 weeks, there was a greater prevalence of glomerulosclerosis and tubulointerstitial (TI) lesions than in control cohorts fed standard laboratory chow.⁴ In the normal guinea pig, a 2% dietary cholesterol supplement given over 70 days produced elevations in total plasma cholesterol, free cholesterol, and phospholipid. Thirty days after the cholesterol supplement was started, there was an increase in the mesangial matrix with mesangial hypercellularity that became even more pronounced by day 70. Also at day 70, glomeruli from the animals manifested a substantial increase in the number of macrophages within the mesangium; this raised the speculation that an intraglomerular monocytic infiltration might participate in the development of a progressive glomerular lesion.⁵

In rats with experimental nephrotic syndrome initiated with puromycin aminonucleoside (PA), feeding a 4% cholesterol/1% cholic acid dietary supplement resulted in both a functional and morphologic exacerbation of the disorder. Manifestations included a decline in glomerular filtration rate (GFR), a greater number of mesangial macrophages, and a higher frequency of glomerulosclerosis lesions.⁶ These observations strongly suggest that cholesterol feeding to normal and nephrotic laboratory animals produces or exacerbates glomerular injury and that lipid-lowering agents should be ameliorative.

Experimental lipid-lowering intervention studies

In the nephrotic state, impaired mevalonate metabolism by the kidney may contribute to enhanced cholesterologenesis by increasing delivery of mevalonate to the liver. Also, nephrosis *per se* seems to stimulate hydroxymethylglutaryl/coenzyme A (HMGCoA) reductase activity in the liver, thereby providing an additional enhancement of hepatic cholesterologenesis.⁷ In the rat 5/6 nephrectomy model of chronic renal failure, surgically ablated animals given a 10-week course of clofibrate had significant reductions in serum cholesterol, urine albumin excretion, and prevalence of glomerulosclerosis. In the same model, the HMGCoA reductase inhibitor mevinolin also was used. It lowered serum lipids, reduced albuminuria, and diminished the prevalence of glomerulosclerosis lesions.⁸

In another model of progressive glomerular disease, both clofibrate and mevinolin were efficacious in reducing serum lipids, albumin excretion, mesangial matrix expansion

and cellularity, and the percentage of glomeruli with glomerulosclerosis lesions. These effects were independent of changes in glomerular microcirculatory hemodynamic determinants.⁹

In the experimental nephrotic syndrome produced by PA, HMGCoA reductase inhibition ameliorated progressive glomerular damage, both functionally and histologically, in association with significant reductions in serum cholesterol. This benefit was independent of changes in proteinuria and blood pressure.¹⁰ In the same model, the bile acid sequestrant cholestyramine significantly reduced recurrent proteinuria and frequency of glomerulosclerosis lesions and preserved a normal GFR compared with a cellulose-fed nephrotic control group.¹¹ In contrast to other hypolipidemic agents mentioned above, cholestyramine predominantly lowers elevated serum cholesterol levels and exerts its effect without systemic absorption.

Pathogenesis of cholesterol-induced glomerular injury

Grone et al¹² recently reported that in normal rats fed a high-fat, high-cholesterol diet, the incidence of glomerulosclerosis increased significantly after six months. Glomerulosclerosis induced by the diet was aggravated by unilateral nephrectomy and systemic arterial hypertension, suggesting that altered glomerular hemodynamics may contribute to the sclerosis process. Kasiske et al¹³ have shown that high cholesterol intake had no statistically significant effect on either single-nephron (SN) GFR or SN plasma flow (SNPF) rate. It had dramatic effects, however, on elevating the glomerular capillary hydraulic pressure (P_{GC}), transcapillary hydraulic pressure difference, and mean arterial blood pressure. Kelly and Izui¹⁴ found that a lipid-rich diet caused an earlier death in NZBxW mice with autoimmune lupus nephritis by promoting renal disease in association with lipid in the peripheral capillary loops and mesangium adjacent to immune deposits. The accelerated renal disease was not related to changes in systemic immune parameters, suggesting that the high lipid consumption hastened renal deterioration by some noxious, local "lipid-glomerular capillary" interaction and not by a systemic influence on the immune response. In the study by Kasiske et al,¹³ a relative increase in cholesteryl esters was the principle diet-induced alteration in the major lipid classes in the renal cortex of normal and uninephrectomized rats fed a cholesterol supplement. Although it is unclear how cholesteryl ester accumulation might lead to renal injury, it may be linked to infiltration of renal structures by monocytes that will become tissue macrophages (discussed below).

Along the lines of a "lipid-glomerular capillary" interaction, Kaplan et al¹⁵ examined the effect of short-term cholesterol feeding on renal dynamics in normal rats. Micropuncture analysis revealed that the cholesterol-supplemented diet caused renal vasoconstriction at both the afferent and efferent arterioles and was accompanied by a significant fall in whole-kidney and SNGFR and a rise in P_{GC} . These adverse events were almost

completely prevented by adding the antioxidant probucol to the diet or by infusing a thromboxane (TX) A_2 receptor antagonist. The investigators therefore concluded that native LDL oxidized *in vivo* initiates events leading to TXA₂-mediated vasoconstriction. It is noteworthy that the salutary effect of probucol was independent of its more well-recognized hypolipidemic effect, suggesting that its antioxidant action ameliorates the perturbations produced by cholesterol feeding.

Another potential noxious effect of oxidized LDL is direct mesangial cell injury. It has been demonstrated that oxidized LDL is more toxic to cultured glomerular mesangial cells than the native form.¹⁶

Finally, analysis of glomerular eicosanoid production in response to cholesterol feeding showed that thromboxane B₂ (TXB₂) rose disproportionately to prostaglandin E₂ (PGE₂).¹⁵ This particular imbalance in glomerular eicosanoid generation suggests monocyte/macrophage involvement in the response to cholesterol feeding. It also raises the possibility that this cell type may contribute to the deleterious glomerular microcirculatory effects noted above.

Hypercholesterolemia, glomerular macrophage number, and macrophage functions

We recently investigated whether glomerular macrophages respond to hypercholesterolemia and thereby participate in the propagation of initial *nonimmune* glomerular injury to glomerulosclerosis.^{17,18} In an analogous fashion to the atherosclerotic process (see below), we hypothesized that the hypercholesterolemic state resulting from nephrosis may involve the participation of macrophages.^{19,20} To establish a relationship between hypercholesterolemia and macrophage function, we studied rat peritoneal macrophage phagocytosis and eicosanoid production, as well as the glomerular macrophage number in the acute phase of the experimental nephrotic syndrome produced by PA.¹⁷ Nephrotic rats with the associated secondary hypercholesterolemia and normal animals with an alimentary hypercholesterolemia manifested significantly greater peritoneal macrophage phagocytosis and an augmented *glomerular macrophage number* when compared with normal animals fed standard laboratory chow. The combination of the nephrotic state and superimposed alimentary hypercholesterolemia, however, produced the greatest rise in these parameters. It also was associated with significantly increased production of TXB₂ without any accompanying change in PGE₂ generation by peritoneal macrophages. These data suggest that there may be a synergistic effect between alimentary hypercholesterolemia and the secondary hypercholesterolemia of nephrosis in producing these macrophage functional alterations and increased glomerular macrophage number during peak nephrosis.

The question remains whether the changes in glomerular macrophage number and systemic macrophage functional activity observed during acute nephrosis have any direct bearing on progressive glomerular disease culminating in

glomerulosclerosis. There is an increase in the number of glomerular macrophages during acute PA nephrosis;^{18,21} however, the pathophysiologic significance of these influxing bone marrow-derived monocytes in this *nonimmune* model remains uncertain. Based on the observation that an essential fatty acid deficient (EFAD) diet depletes normal rat glomeruli of resident macrophages,²² we examined the effect of this diet in the progressive model of chronic PA nephrosis.¹⁸ Rats were made EFAD over eight weeks. After receiving PA, they were continued on this diet *only* for the duration of acute nephrosis (i.e., four weeks) and then transferred to standard laboratory chow for the duration of the 18-week study. The recurrent albuminuria and development of glomerulosclerosis that characterize the later stage of this model were significantly blunted in EFAD rats. These beneficial outcomes 18 weeks after PA were associated with significant reductions in the glomerular macrophage number and TXB₂ generation in EFAD rats during acute nephrosis (i.e., two weeks after PA). These findings suggest that modulation of these parameters during early glomerular injury could have important long-term effects on the course of progressive glomerulopathy. More recently, we confirmed the efficacy of reducing both the glomerular and TI macrophage number in preventing progressive glomerular disease: a single dose of whole body X-irradiation during acute nephrosis only (i.e., three days after PA) completely abrogated the above-mentioned chronic sequelae 18 weeks after PA delivery.²³

Analogy of glomerulosclerosis to atherosclerosis

Several researchers have attempted to investigate the pathobiologic similarities between the atherosclerotic process and glomerulosclerosis. In atherogenesis, fatty streaks may develop into fibrous plaques with necrotic, lipid-filled macrophage cores surrounded by proliferating vascular smooth muscle cells (VSMC) and increased amounts of connective tissue. The importance of the monocyte/macrophage in the pathobiology of the atherosclerotic process was reviewed recently by Steinberg et al.²⁴ For many years, the foam cell was thought to arise from smooth muscle cells that migrate into the intima and begin to digest lipids. More recent evidence established that many foam cells are derived from circulating monocytes that adhere to the endothelium, penetrate into the subendothelial space, and there take up lipoproteins to become loaded with cholesteryl esters. The relative ineffectiveness of native LDL in generating foam cells led to the speculation that some modified form of LDL might account for the atherogenicity of LDL.

By combining the newer finding about the properties of oxidized LDL and the information available about the experimental pathology and cell biology of the macrophage, Steinberg et al.²⁴ constructed an hypothesis about the development of the fatty streak lesion based solely on the presence of elevated plasma LDL levels plus the oxidative modification of LDL within the arterial wall. In the presence of a high plasma LDL

concentration, the level of this lipoprotein also is increased in the intima of the vessel wall. Within the vessel wall, the native LDL is oxidized by either endothelial cells, macrophages, or smooth muscle cells, contributing to the subsequent recruitment of circulating monocytes. Once within the arterial wall, the monocyte undergoes phenotypic modification and becomes a tissue macrophage. Its return to the plasma compartment is now inhibited by the oxidized LDL. The tissue macrophage now takes up oxidized LDL via the "scavenger" pathway and becomes a foam cell.

In our more recent experiments, we extended this analogy an additional step. Ding et al²⁵ postulated that since hypercholesterolemia aggravates experimental progressive glomerular injury and increases the renal macrophage number, a macrophage-derived peptide growth factor, such as transforming growth factor (TGF)-beta, may serve as the critical effector mechanism. TGF-beta is secreted by activated macrophages and is a pluripotent growth factor that can either inhibit or stimulate cellular proliferation depending on the target cell type, state of differentiation, or surrounding milieu. This growth factor generally has been found to have marked effects on extracellular matrix production, such as fibronectin. TGF-beta also inhibits the degradation of matrix proteins. Thus, its net effect is an accumulation of excessive extracellular matrix. Since matrix overproduction is an aberrant process common to both the formation of the fibrous plaque in the vessel wall and the glomerulosclerotic lesion following initial glomerular injury, macrophage-derived TGF-beta may be an important mediator mechanism.

We noted that glomerular messenger ribonucleic acid (mRNA) levels for TGF-beta and fibronectin were significantly elevated as the glomerulosclerosis lesion was evolving in our rat model of progressive nephrotic syndrome.²⁵ Furthermore, the increments in the gene expression for TGF-beta and fibronectin were temporally correlated with the phase of maximal glomerular macrophage infiltration and peak serum cholesterol levels. Cholesterol feeding to both normal and nephrotic rats produced a further significant increase in the glomerular mRNA levels of TGF-beta and fibronectin. Immunohistochemical labeling for macrophages and intracellular TGF-beta supported this infiltrating mononuclear leukocyte as the source of TGF-beta. These recent findings thus identify a novel interaction among hypercholesterolemia, augmented glomerular macrophage accumulation, and up-regulated glomerular TGF-beta and fibronectin gene expression. These perturbations within the acutely inflamed glomerulus constitute an early pathobiologic determinant for the later development of mesangial matrix expansion and glomerulosclerosis.

Clinical data

Enhanced TGF-beta expression recently has been identified in the renal biopsy specimens of patients with a diverse array of glomerular disorders, including diabetes mellitus, immunoglobulin A nephritis, and membranous glomerulonephritis.^{26,27}

Increased macrophages also have been identified in the glomeruli of patients with focal and segmental sclerosis, the clinical counterpart of our rodent model of progressive nephrotic syndrome.²⁸ Thus, clinical data are beginning to corroborate experimental observations regarding the maladaptive effects of the infiltrating renal macrophage and its elaboration of the pluripotential peptide growth factor TGF-beta.

Summary

In analogy with atherosclerosis, the hypercholesterolemia accompanying glomerular injury could mediate, in part, the transition from initial injury to glomerulosclerosis by an increase in glomerular macrophages. Oxidized LDL can be generated by endothelial cells, macrophages, and, theoretically, contractile glomerular mesangial cells. It remains to be determined whether oxidized LDL can enhance the recruitment of circulating monocytes into glomerular and TI compartments in the vessel wall.²⁴ After taking up this modified form of LDL, glomerular macrophages could elaborate peptide mitogens or perturb glomerular eicosanoid balance, thereby leading to glomerulosclerosis. More specifically, locally generated oxidized LDL can be toxic to the contractile glomerular mesangial cell. This same moiety can mediate enhanced local generation of TXB₂ (perhaps by the macrophage itself), thereby resulting in vasoconstriction of the glomerular microcirculation and, in turn, acute declines in SNPF and SNGFR. Infiltrating monocytes gaining access to the glomerular mesangium in temporal association with the glomerular injury and augmented by the accompanying secondary hypercholesterolemia also could be secreting peptide growth factors (e.g., interleukin-1, tumor necrosis factor,²⁹ and TGF-beta²⁵). Such peptide growth factors could potentially initiate perturbations in mesangial cell function (i.e., increased proliferation and matrix overproduction) and serve as harbingers of glomerulosclerosis. Further support for this pathobiologic schema is derived from recent intervention strategies implemented during acute PA nephrosis that decrease the glomerular macrophage number (i.e., EFAD¹⁸ and whole body X-irradiation²³) and confer protection against progressive glomerulopathy. These initial experiments further underscore the important role of the glomerular macrophage in propagating initial glomerular injury to glomerulosclerosis.

Short-term (i.e., weeks) investigations indicate HMGCoA reductase inhibitors, fibric acids, and probucol have lipid-lowering effects in patients with secondary hyperlipidemia of nephrosis. At this time, however, no well-controlled, long-term human studies have been conducted to demonstrate whether hypolipidemic therapy would retard or arrest progressive glomerular injury.

References

1. Marsh JB, Sparkes CE. Lipoproteins in experimental nephrosis: Plasma levels and composition. *Metabolism* 1979; 28:455-65.

2. Norum KR. Familial lecithin cholesterol acyltransferase deficiency. In: Miller ME, Miller GJ (eds). *Clinical and Metabolic Aspects of High Density Lipoproteins*. Amsterdam, Elsevier. 1984; 297-324.
3. Peric-Golia L, Peric-Golia M. Aortic and renal lesions in hypercholesterolemic adult, male, virgin Sprague-Dawley rats. *Atherosclerosis* 1983; 46:57-65.
4. Kasiske BL, O'Donnell MP, Schmitz P, Kim Y, Keane WF. Renal injury of diet-induced hypercholesterolemia. *Kidney Int* 1990; 37:880-91.
5. Al-Shebeb T, Frohlich J, Magil AB. Glomerular disease in hypercholesterolemic guinea pigs: A pathogenetic study. *Kidney Int* 1988; 33:498-505.
6. Diamond JR, Karnovsky MJ. Exacerbation of chronic aminonucleoside nephrosis by dietary cholesterol supplementation. *Kidney Int* 1987; 32:671-78.
7. Golper TA, Feingold KR, Fulford MH, Siperstein MD. The role of circulating mevalonate in nephrotic hypercholesterolemia in the rat. *J Lipid Res* 1986; 27:1044-51.
8. Kasiske BL, O'Donnell MP, Garvis WJ, Keane WF. Pharmacologic treatment of hyperlipidemia reduces glomerular injury in rat 5/6 nephrectomy model of chronic renal failure. *Circ Res* 1988; 62:367-74.
9. Kasiske BL, O'Donnell MP, Cleary MP, Keane WF. Treatment of hyperlipidemia reduces glomerular injury in obese Zucker rats. *Kidney Int* 1988; 33:667-72.
10. Harris KPG, Purkerson ML, Yates J, Klahr S. Lovastatin ameliorates the development of glomerulosclerosis and uremia in experimental nephrotic syndrome. *Am J Kidney Dis* 1990; 15:16-23.
11. Diamond JR, Hanchak NA, McCarter MD, Karnovsky MJ. Cholestyramine resin ameliorates chronic aminonucleoside nephrosis. *Am J Clin Nutr* 1990; 51:606-11.
12. Grone H, Walli A, Grone E, Niedmann P, Thiery J, Seidel D, Helmchen U. Induction of glomerulosclerosis by dietary lipids. *Lab Invest* 1989; 60:433-40.
13. Kasiske BL, O'Donnell MP, Schmitz PG, Kim Y, Keane WF. Renal injury of diet-induced hypercholesterolemia in rats. *Kidney Int* 1990; 37:880-91.
14. Kelly VE, Izui S. Enriched lipid diet accelerates lupus nephritis in NZB x W mice. *Am J Pathol* 1983; 111:288-94.
15. Kaplan R, Aynedjian HS, Schlondorff D, Bank N. Renal vasoconstriction caused by short-term cholesterol feeding is corrected by thromboxane antagonist or probucol. *J Clin Invest* 1990; 86:1707-14.
16. Keane WF, Phillips J, Kasiske BL, O'Donnell MP, Kim Y. Injurious effects of low density LDL on human mesangial cell. *Kidney Int* 1990; 37:509A.
17. Diamond JR, Pesek I, McCarter MD, Karnovsky MJ. Altered functional characteristics of rat macrophages during nephrosis: Synergistic effects with hypercholesterolemia. *Am J Pathol* 1989; 135:711-18.
18. Diamond JR, Pesek I, Ruggieri S, Karnovsky MJ. Essential fatty acid deficiency during acute puromycin nephrosis ameliorates late renal injury. *Am J Physiol* 1989; 257:F798-F807.
19. Diamond JR, Karnovsky MJ. Focal and segmental glomerulosclerosis: Analogies to atherosclerosis. *Kidney Int* 1988; 33:917-24.
20. Diamond JR. Effects of dietary interventions on glomerular pathophysiology. *Am J Physiol* 1990; 258:F1-F8.
21. Schreiner GF, Cotran RS, Unanue ER. Modulation of Ia and leukocyte common antigen expression in rat glomeruli during the course of glomerulonephritis and aminonucleoside nephrosis. *Lab Invest* 1984; 51:524-33.
22. Lefkowitz JB, Schreiner GF. Essential fatty acid deficiency depletes rat glomeruli of resident macrophages and inhibits angiotensin II-induced eicosanoid synthesis. *J Clin Invest* 1987; 80:947-56.
23. Diamond JR, Pesek-Diamond I. Sublethal irradiation during acute puromycin nephrosis prevents late renal injury: Role of macrophages. *Am J Physiol* 1991; 260:F779-F786.
24. Steinberg D, Parthasarathy S, Carew TE, Khoo JC, Witztum JL. Beyond cholesterol: Modifications of low-density lipoprotein that increase its atherogenicity. *N Engl J Med* 1989; 320:915-24.
25. Ding G, Diamond IP, Diamond JR. Cholesterol, macrophages and the gene expression of TGF-beta 1 and fibronectin during nephrosis. *Am J Physiol* 1993; 264:F577-F584.
26. Yamamoto T, Nakamura T, Noble N, Ruoslahti E, Border WA. Expression of transforming growth factor beta is elevated in human and experimental diabetic nephropathy. *Proc Natl Acad Sci USA* 1993; 90:1814-18.
27. Yoshioka K, Takemura T, Murakami K, Okada M, Hino S, Miyamoto H, Maki S. Transforming growth factor-beta protein and mRNA in glomeruli in normal and diseased human kidneys. *Lab Invest* 1993; 68:154-63.
28. Magil AB, Cohen AH. Monocytes and focal glomerulosclerosis. *Lab Invest* 1989; 71:404-14.
29. Diamond JR, Pesek I. Glomerular tumor necrosis factor and interleukin-1 during acute aminonucleoside nephrosis: An immunohistochemical study. *Lab Invest* 1991; 64:21-28.

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THE MARK OF EXCELLENCE

Vignette of medical history: George Washington and smallpox

Joseph M. Miller, M.D.

*Dr. Miller is a retired surgeon from
Timonium, Maryland.*

The eighteenth century witnessed a great stimulation of the public health field when an effective preventive measure for smallpox was introduced. Smallpox was one of the feared killers, ranking with plague, typhoid fever, typhus fever, and diphtheria as prime causes of death. Variolation (inoculation) with the smallpox virus was successful, but dangerous due to the associated mortality.¹

The phenomenon of acquired immunity must have been recognized for centuries because one attack provided permanent protection. As transmission was from person to person, direct contact with infected material could be used to give smallpox to another individual. Scales from drying pustules were blown into the nose or thick liquid from a pustule was rubbed into a small scratch to transmit the disease.

Chinese physicians at the end of the eleventh century practiced inoculation after the method was introduced from India. In the eighteenth century, a Greek doctor, Giacomo Pylarini of Smyrna, immunized by rubbing some of the thick liquid into a needle scratch. Emanuel Timoni, another Greek physician in Constantinople, wrote to John Woodward in London about the procedure; a description was printed in the *Philosophical Transactions of the Royal Society* in 1714, but the concept did not become popular until seven years later. After King George I had his grandchildren inoculated, the practice became fashionable. Benjamin Jetsy is reported to have inoculated and protected his wife and two sons with purulent material from cows with smallpox. Another individual named Plett vaccinated three children using a pocket knife to make the incision.²

At the age of 19, George Washington learned from personal experience the difficulties arising from smallpox.^{3,4} Accompanying his oldest half-brother, Lawrence, to Barbados, he contracted the disease and was ill for three weeks. Yet few physicians are aware that a command army order issued by General Washington during the American Revolution made a significant contribution to preventive medicine and public health. Washington knew to what extent various types of illness sapped the strength of the Continental army and prevented it from being militarily effective. During the years 1775-1783, 11% to 35% of the troops were incapacitated from illness; in the

earliest days of the conflict, a considerable portion of the loss was due to smallpox.⁵

In September 1775, the prospect of capturing Canada was most alluring to the Continental Congress. The march from Augusta to the St. Lawrence River, commanded by Colonel Benedict Arnold, was difficult and the diminution in troop strength was considerable. Although a second prong under General Richard Montgomery had started from upper New York, sickness, desertion, and expired enlistments depleted the combined force. Then, smallpox appeared. Because there was no official inoculation policy, many of the men sought local help or attempted to immunize themselves.

By January 1776, the contagion was spreading rapidly. Although fresh troops arrived, the military attack was blunted. Soon 100 men were ill with smallpox; by early April, 700 men—nearly half the force—had the disease. The collapse of the Canadian effort was imminent.

The Americans retreated, but by the time they reached Isle aux Noix, 2,000 had smallpox, another 2,000 had dysentery or malaria, and only 3,000 were fit for duty. This campaign, with a 40% mortality rate, was the most disastrous of the war. In addition, the movement of the patients with smallpox into New England posed a great threat to the civilian population.

During this period, the British forces had been under siege in Boston and they evacuated the city on March 17, 1776. Washington was naturally fearful of entering a city known to harbor the disease. With the Canadian experience in mind, he had one regiment immunized before the city was entered. Subsequently, with the permission of the Massachusetts legislature, the troops stationed in Boston and many of the local inhabitants also were inoculated. The mortality statistics from the immunization were phenomenally low: 1 in 500 soldiers and 2 of 5,000 Bostonians.

Because of the success of this venture and his great interest in smallpox, Washington decided that inoculation was a necessity. At Morristown, New Jersey, on January 6, 1777, he mandated that his troops be immunized while preparing for the spring campaigns. From February to May, the staff of Dr. William Shippen, Jr., inoculated regiments at three areas around Philadelphia and at a number of mobilization centers. Again, results were excellent; for supervised inoculation, mortality was less than 1% (mortality from natural infection was 16%).

Although many thousands of military personnel remained to be immunized, a milestone had been reached. The procedure eliminated a major obstacle to recruitment and the army welcomed thousands of men.

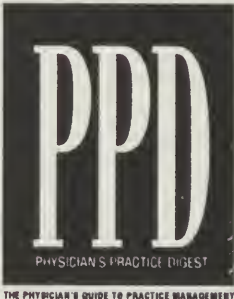
Command varolation against smallpox may be among the significant events that led to a favorable conclusion of the revolutionary war.⁶ The preservation and enhancement of military power effected by required inoculation was certainly a distinct help. In his correspondence with Congress and the governors of several states during this period, Washington expressed remarkably clear ideas about the communicability of

smallpox, the need for isolation hospitals, and the preventive effects of inoculation. He deserves credit for this major contribution to preventive medicine.

References

1. Cartwright FL, Biddiss, MD. *Disease and History*. New York: Dorset Press. 1972; 428.
2. Kinyoun JJ. Vaccination. In: *The Encyclopedia Americana*. New York: Americana Corporation. 1954; 27:624-633.
3. Knox JHM Jr. The medical history of George Washington, his physicians, friends, and advisers. *Bull Hist Med* 1933; 1:174-91.
4. Willius FA, Keyes TE. The medical history of George Washington (1732-1799). *Proceedings of the Staff Meetings of the Mayo Clinic* 1942; 17:92-96, 107-12, 116-21, 180.
5. Blanco RL. *Physicians of the American Revolution*. Jonathon Potts. New York: Garland STPM Press. 1979; 276.
6. Fenner F, Henderson DA, Arita I, Jezek Z, Ladnyi ID. *Smallpox and Its Eradication*. Geneva: World Health Organization. 1988; 1460. ■

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When the Doctor is Out

JOSEPH GAGLIARDI, M.D.: REVOLUTIONARY PHYSICIAN

At first light on his days off, Joseph Gagliardi, M.D., can be seen sneaking out of his house wearing a wig and a three-cornered hat. Other days, he appears in the unremarkable attire of a family physician practicing in the year 1994. On this morning, however, dressed in his colonial finery, he is Dr. Alexander Dobbs, a fictional regimental physician and surgeon for General George Washington's Army in the year 1777.

Dr. Dobbs was born of Dr. Gagliardi's interest in the history of medicine, his commitment to education, and a request from a local teacher three years ago to give a lecture on colonial medicine to a group of social studies students. Although the lecture was very well received, Dr. Gagliardi decided a more dynamic approach would be to allow students to interact with a physician from the colonial period.

He placed Dr. Dobbs at the beginning of the revolutionary war because of the significant victories and losses that occurred in 1777. "Despite the victories at Trenton, Princeton, and Saratoga, the war for independence was floundering. The small, poorly fed and equipped Continental army suffered from numerous maladies.

For every soldier dying from battle wounds, ten died from disease. At the close of the year, many patriots and military leaders had grave doubts that the war could be won," said Dr. Gagliardi.

Through the character of Dr. Dobbs and the backdrop of the American Revolution, Dr. Gagliardi planned to link historical events and colonial medicine. To make Dr. Dobbs as authentic as possible, Dr. Gagliardi spent a year researching late eighteenth century American life and medicine. He read volumes of material,

not only on general history, but on the dress, social customs, and scientific understanding of the period. No detail escaped him; it took a seamstress four months to sew the outfit he would wear as Dr. Dobbs.

Dr. Gagliardi's hard work was evident in Dr. Dobbs's recent presentation to American history students at the Owen Brown Middle School in Columbia, Maryland. Students were captivated by his stories of colonial life and somewhat shocked by his simulations of an amputation and a bloodletting.

Many students initially find it difficult to transport themselves back in time, asking Dr. Dobbs questions such as "Do you drive a car?" or "Do you eat pizza?" His persistence is remarkable, however. When one student asked Dr. Dobbs why he couldn't simply give his patients aspirin if they were in pain, he replied, "Aspirin? I'm sorry sir, but I am not familiar with that herb."

Once students realize that Dr. Gagliardi will not come out of character, they begin to adapt their questions to the context of their eighteenth century visitor. They become curious about a variety of topics including women's roles, disease causation, and pain relief.

Teachers also are delighted with the unique learning experience Dr. Dobbs brings to their classrooms. Ms. Brenda Bush, a history teacher at Owen Brown Middle School, said her students especially liked the roleplaying; she felt Dr. Dobbs had given them historical insight. Ms. Kelly Reichart, who teaches social studies at Loch Raven High School, highly recommends a visit from Dr. Dobbs. "When I heard students discussing him on their lunch hour, I knew he had really made an impression."

Dr. Gagliardi has been visiting schools as a public service for the past two years.



Dr. Gagliardi as Dr. Alexander Dobbs, fictional regimental physician and surgeon for General George Washington's Army.

In 1993, he reached more than 1,200 students in 15 schools across Maryland.

The unique combination of medicine and social sciences in Dr. Gagliardi's outreach to Maryland students seems very natural in light of his own educational background. As an undergraduate at the University of Notre Dame, he studied sociology and education, intending to become a social studies teacher. During his senior year, however, a course on the sociology of medicine sparked his interest in medicine.

After graduating from Notre Dame, Dr. Gagliardi joined the Navy. In 1971, he found himself in Vietnam, an experience that made him "sick and tired of all the suffering" and increased his commitment to the study of medicine. While still in the Navy, he began taking pre-medical courses and in 1975 was accepted to study medicine at the State University of New York at Buffalo. In 1982, he completed his family practice residency at the University of Maryland.

Through more than a decade of full-time medical practice, Dr. Gagliardi has maintained his enthusiasm for teaching. In addition to his appearances throughout the state as Dr. Dobbs, he continues to teach on a variety of subjects to medical students, physicians, and other health professionals.

By introducing his audiences to the medical practices of the past, Dr. Gagliardi hopes to enhance their appreciation for modern medicine. And given the tenacity of Dr. Dobbs—who has been practicing medicine for well over two centuries—it seems likely that Dr. Gagliardi will successfully reach this goal.

MARION CERASO, M.H.S.

Ms. Ceraso is a health educator at Med Chi. ■



Dr. Gagliardi as Dr. Dobbs, simulating an amputation on a student at Owen Brown Middle School in Columbia, Maryland.

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Imaging Case of the Month

Stress Fractures

A 26-year-old white male athlete who ran several miles every day presented with severe right-sided anterior tibial pain. He stated that for the last three years he experienced intermittent lower extremity pain that increased in direct proportion to his degree of athletic activity. The pain improved with rest, but never completely subsided. He decided to come for evaluation and treatment because his condition completely prevented any type of running and he could feel a "lump" on the

anterior tibial shaft corresponding to the maximal area of discomfort. Two x-ray views of the right lower leg area were ordered; the lateral film is shown in **Figure 1**. A triple phase bone scan (TPBS) was then ordered to evaluate whether the positive x-ray finding was active or "hot" with uptake of the injected isotope (**Figure 2**). The most reliable and sensitive test to detect stress fractures is the TPBS, which typically shows focal accumulation of the technetium isotope in positive cases.¹



Figure 1. Lateral view of the right lower leg demonstrating some anterior cortical thickening of the tibial shaft. The linear/horizontal, faint or subtle, lucent line in the mid-anterior tibial cortex (black arrowheads) corresponds to the maximal area of pain and the palpable "lump."



Figure 2. Lateral view of the delayed images of a triple phase bone scan of the right lower leg. Black arrowhead points to increased uptake of the technetium-polyphosphate isotope ("hot spot") corresponding to the x-ray abnormality and the clinical area of maximal pain consistent with anterior tibial shaft stress fracture.

Table 1. Tibial stress fractures

| | Anterior | Posterior |
|-------------------|--------------------|--------------|
| Occurrence | rare | common |
| Activity | gymnastics, ballet | running |
| X-rays | positive | negative |
| Healing | months to years | 4 to 6 weeks |
| Surgery | common | rare |

Almost all studies have shown that the most common sites for stress fractures in athletes are the lower extremities, particularly the tibia. The most common site of tibial stress fractures is the posterior tibial cortex, especially the proximal third.¹ The least common stress fracture of the lower extremities is the anterior tibial stress fracture shown in **Figures 1 and 2**.

Stress fractures of the anterior mid-tibial shaft were first reported in ballet dancers.^{2,3} Since then, additional cases have been identified in other athletes, primarily those who engage in significant jumping (e.g., gymnasts, basketball players) or running activity; there is one case report in a professional football player.^{4,5}

Unlike the negative x-rays usually associated with posterior tibial stress fractures, radiographs of anterior tibial stress fractures typically reveal an anterior cortical thickening and a horizontal fissure or "black line" that is associated with poor healing, often resulting in non-union. Whereas posterior tibial stress fractures usually heal with rest, anterior tibial stress fractures often require electrostimulation or bone grafting, as well as months or years of inactivity, treatment, and follow-up.

Adding to the difficulty, TPBS often shows only a minimally or mildly positive study despite obvious radiographic abnormalities. In such cases, negative TPBS may

be associated with bone infarct in the area of the initial anterior stress fracture, which adds to the generally poor prognosis.⁶⁻⁹

Anterior mid-tibial cortical stress fractures are unusual in location, x-ray appearance, difficulty and length of treatment, need for surgical intervention, and higher incidence among ballet dancers and gymnasts (**Table 1**). Sports medicine physicians, orthopedic surgeons, and radiologists should be aware of this unusual entity and its often devastating effect on athletic careers.

References

1. Martire JR. The role of nuclear medicine scans in evaluating pain in athletic injuries. *Clin Sports Med* 1987; 6:713-37.
2. Burrows FJ. Fatigue infarction of middle of tibia in ballet dancers. *J Bone Joint Surg* 1956; 38(B):83-86.
3. Miller EH, Schneider HJ, Bronson JL, McLain D. A new consideration in athletic injuries. The classical ballet dancer. *Clin Orthop* 1975; 111:181-91.
4. Brahms MA, Fumich RM, Eppolito VT. Atypical stress fracture of the tibia in the professional athlete. *Am J Sports Med* 1980; 8:131-32.
5. Rettig AC, Shelbourne KD, McCarroll JR, Bisesi M, Watts J. The natural history in treatment of delayed union stress fractures of the anterior cortex of the tibia. *Am J Sports Med* 1988; 16:250-55.
6. Blank S. Transverse tibial stress fractures: A special problem. *Am J Sports Med* 1981; 9:322-25.
7. Blank S. Transverse tibial stress fractures. *Am J Sports Med* 1987; 15:597-602.
8. Green NE, Rogers RA, Lipscomb AB. Non-union of stress fractures of the tibia. *Am J Sports Med* 1985; 13:171-76.
9. Wilcox JR, Moniot AL, Grenn JR. Bone scanning in the evaluation of exercise-related stress injuries. *Radiology* 1977; 123:699-703.

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PHYSICIAN AUTHORS WANTED

"Imaging Case of the Month" is a regular feature of the Maryland Medical Journal. Coordinated by the Maryland Radiological Society, the cases presented provide a review of a broad range of diseases and pathological processes of interest to a wide range of specialists.

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A Clinical Moment with Endocrinology and Metabolism

Postpartum thyroiditis

Dear Doctor:
I would like your opinion about a 24-year-old woman who developed signs and symptoms suggestive of hyperthyroidism approximately 10 weeks after giving birth to her first child. Her thyroid function tests were as follows: thyroxine (T_4) 193 nmol/L (normal, 57-154); triiodothyronine uptake resin (T_3 RU) 0.32 (normal, 0.25-0.35); and thyroid-stimulating hormone (TSH) <0.03 mU/L (normal, 0.5-5.0). How can I tell whether she has Graves' disease or "postpartum thyroiditis"? If she does have postpartum thyroiditis, what is the appropriate therapy?

The development of thyroid dysfunction in the postpartum period is quite common. It is estimated that 5% of all women who give birth will have postpartum thyroiditis; a smaller percentage will develop Graves' disease.

Postpartum thyroiditis is probably an autoimmune disease, since most women who develop it have positive antithyroid antibodies. Although the disease typically occurs in postpartum women, it can affect nonpostpartum women as well as men: in these groups it is called "painless thyroiditis" or "lymphocytic thyroiditis." It shares some clinical features with subacute thyroiditis (also called DeQuervain's thyroiditis) in that it often follows a triphasic course, with a period of hyperthyroidism, followed by a period of hypothyroidism, and then a return to the euthyroid state. Some patients present only with hypothyroidism, perhaps because the hyperthyroid phase was relatively mild. The hyperthyroidism in postpartum thyroiditis, like that seen in subacute thyroiditis, is caused by thyroid inflammation, with follicle disruption and leakage of hormonal stores into the circulation. Thus, the thyroid is not really "overactive"; in fact, the 24-hour radioactive iodine uptake is very low, reflecting both thyroid malfunction as well as inhibition of pituitary TSH (thyroid-stimulating hormone) secretion by the high levels of circulating thyroid hormones.

Despite the similarities, postpartum thyroiditis differs from subacute thyroiditis in many ways. Postpartum thyroiditis is painless, has a tendency to recur with subsequent pregnancies, and may develop into permanent hypothyroidism in about 25% of patients. By contrast, subacute thyroiditis is extremely painful, rarely develops a second time, and rarely, if ever, causes permanent thyroid impairment.

It is important to distinguish postpartum thyroiditis from Graves' disease. Postpartum thyroiditis spontaneously resolves without therapy, while Graves' disease always requires specific treatment. It can be quite difficult to tell the two entities apart, however, since both occur in young

women presenting with hyperthyroidism and a small diffuse goiter. If ophthalmopathy is present, Graves' disease is far more likely. Positive antithyroid antibodies are seen in both conditions and are therefore not helpful. A 24-hour radioiodine uptake should help distinguish between the two diseases; the radioiodine uptake will be *elevated* in Graves' disease and *low* in postpartum thyroiditis. The procedure presents a potential problem in breastfeeding women because radioiodine is secreted into breast milk, but with the use of ^{123}I , which has a half-life of 13 hours, breastfeeding need only be suspended for two or three days. Another test that could be helpful in diagnosing Graves' disease is the measurement of "thyroid-stimulating immunoglobulins" (TSI) in the blood, which are not present in postpartum thyroiditis. The test is technically difficult, however, and false negative results are possible even in clear-cut Graves' disease.

If the patient is found to have the clinical and laboratory features of postpartum thyroiditis, symptomatic treatment with beta-adrenergic blockers is all that is indicated. The hyperthyroid phase of the illness should resolve in four to eight weeks. The hypothyroid phase usually does not require treatment, but thyroxine therapy is indicated in symptomatic patients. Some studies have shown that hypothyroidism due to postpartum thyroiditis can cause mild depression, but it is rarely the cause of severe postpartum depression. If therapy with thyroid hormone is instituted, it should be discontinued after three to six months, since most patients will have resumed normal thyroid function. About 25% of patients, however, will require life-long replacement therapy. Patients who have had one episode of postpartum thyroiditis should be told that it can recur with subsequent pregnancies.

Screening pregnant women for antithyroid antibodies early in pregnancy or in the postpartum period will detect most of those at risk for development of the disease (about 10% of women are antibody positive; of these, 50% develop postpartum thyroiditis). However, the cost effectiveness of screening *all* pregnant women has not been established.

DAVID S. COOPER, M.D.

Dr. Cooper is associate physician-in-chief and director of the Division of Endocrinology & Metabolism, Department of Medicine, Sinai Hospital of Baltimore, and associate director of the Thyroid Clinic and associate professor of medicine at the Johns Hopkins University School of Medicine, Baltimore, Maryland.

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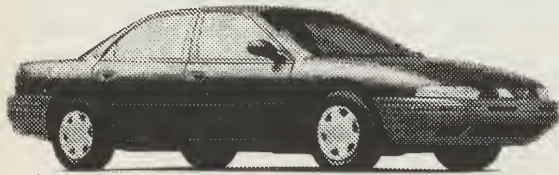
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WORD ROUNDS

Bart Gershen, M.D.

Radicals

Etymology is all about the origin of terms—their roots. The Latin for root is *radix*. From it we derive **radical**, the foundation or root of something. In current jargon, *radical* change involves replacing some *root* aspect of one's life. It's ironic that today's "radical" was yesterday's fundamentalist.

Of course, mathematicians use the radical sign to signify the square root of a number. And roots are an integral feature of most plants. Occasionally, they are edible and become a dietary staple, such as the succulent **radish**, whose root is admired by many gourmands.

The Greek letter *delta* is the fourth letter of their alphabet, corresponding to our letter 'D'. *Delta*, in turn, was borrowed from the Phoenicians, whose Semitic tongue may still be recognized in modern Hebrew. The first four letters of the Hebrew alphabet are *aleph*, *beth*, *gimel*, *daleth*. Those of the Greek alphabet are *alpha*, *beta*, *gamma*, *delta*. The similarity is quite striking and furthers the theory that virtually all languages have evolved from an ancestral parent tongue called Indo-European.

The letter *delta* is designed as a triangle. As a river flows into a bay or estuary it deposits mud and silt. This fluvial deposit is often in the shape of a triangle as well. Thus, it too is called a **delta**. A muscle which arises from the acromion process and the outer third of the clavicle, inserts onto the lateral shaft of the upper humerus, and abducts the arm, is also somewhat triangular in shape. We call it the

deltoid muscle (Greek *delta* + *oeides* 'like'—that is, delta-like).

The **acromion** (Greek *akros* 'tip, end, or point' + *omos* 'the shoulder') process is at the distal end of the scapular spine. It joins the lateral end of the clavicle to form the acromio-clavicular junction—the tip of the shoulder. **Acrocyanosis** is bluish discoloration of the *tips* of the fingers. **Acromegaly** (*akros* + Greek *megalo* 'large, great, or powerful'—as in *megalomania* or *megalocyte*) is enlargement of the *distal* appendages. An **acrobat** (*akros* + Greek *banein* 'to walk') walks on *tiptoes*. And an **acronym** (*akros* + Greek *onym* 'name') is a word constructed from the *tips* or first letters of a phrase, such as **radar** from **radio** detection and ranging, or **laser** from light amplification by stimulated emission of radiation. **Quasars** are **quasi** stellar objects—remote galaxies at the edge of time.

Governments and the military are geniuses at manufacturing acronyms. The recently concluded **NAFTA** Treaty (North American Free Trade Agreement), **NATO** (North Atlantic Treaty Organization), and **UNESCO** (United Nations Educational, Scientific, and Cultural Organization) are but three examples. During World War II, one could have become a **WAC** (Women's Army Corps) or a member of the **WAVES** (Women Appointed for Voluntary Emergency Service). One also could have gone **AWOL** (absent without leave). Worse yet, one might have been assigned to **CINCPAC** (Commander in Chief, Pacific). Americans abhorred the **gestapo**

(*geheime staatzpolizei* 'secret state police'), while our gallant bomber pilots tried desperately to avoid the **flak** exploding around their airplanes (*fliegerabwehrkanonen* 'bursting anti-aircraft fire'). Contemporary pilots are quite familiar with the Russian **MIG** planes, an acronym for the aircraft's designers, Artem **Mikoyan** and Mikhail **Gurevich**.

One may belong to **CORE** (Congress of Racial Equality) or to **NOW** (National Organization for Women). One may travel to **Pakistan**, which was originally composed of Punjab, Afghan provinces, Kashmir, Sind, and Baluchistan. (*Pakistan* has a double meaning since it also means 'holy country' in its native language, Urdu.) One may fly **Quantas** Airlines (Queensland and Northern Territories Aerial Services) from Australia to Italy and rent a new **Fiat** car (Fabbrica Italiana Automobili Turini, from the manufacturer which is located in Turin) to explore the countryside.

The world of computers has dazzled us with its acronymic concoctions. **BASIC**, a simple programming language, represents **B**eginners **A**ll-purpose **S**ymbolic **I**nstruction **C**ode. **COBOL**, another programming tool, means **C**ommon **B**usiness-**O**riented **L**anguage. **GIGO**, a term with which you may be familiar—having read this column before—means garbage in, garbage out. The most recent innovation refers to the appearance of text on the computer monitor. It is **wysiwyg** (pronounced "wizzywig") and it means what you see is what you get.

The **clavicle** articulates laterally with the acromion process and medially with the **manubrium** sterni. The word *clavicle* originates from the Latin *clavicula* 'little key', which in turn

derives from *clavis* 'a key'. Obviously some disingenuous early prosector thought the clavicle looked like something that unlocks doors. Anatomists, despite external appearance, are really quite imaginative, requiring no ink blots to stimulate their creative psyche. The **manubrium**, for instance, arises from Latin *manus* 'hand' + *habere* 'to hold'—that is, to hold in the hand. But to hold what? Answer: the mid-portion or body of the sternum, which is known as the **gladiolus**. *Gladiolus* means 'a little sword' and stems from the Latin *gladius* 'sword'—as in **gladiator**. The very tip of the sternum is called the **ensiform** process, which means 'sword-shaped' in Latin. The Greek word for this bony protuberance is *xiphoid*, which means the same thing. The entire sternum, therefore, is conceived of as a hand holding a sword. (Incidentally, the **gladiolus**, a member of the Iris family, has sword-shaped leaves.)

The Latin word *clavis* (key) may be encountered in several English disguises. A **conclave** refers to a gathering of Cardinals charged with electing a new Pope. They are confined within a room and locked in with a key from the outside (Latin *con* 'with' + *clavis*). An **enclave** (French *enclaver* 'enclosed' from Latin *in* + *clavis*) refers to land which is completely enclosed within foreign territory—as West Berlin within East Germany during the good old days. On the map an enclave resembles a key fitting into a lock.

J.S. Bach wrote "The Well-Tempered Clavier," a set of 48 preludes and fugues for the seventeenth century instrument the **clavichord**. *Clavier* is French for 'keyboard'. The clavichord succeeded the harpsichord and led to the invention of the **piano**, originally

called the *piano-forte* (Italian *piano e forte* 'soft and loud') by its inventor, Bartolomeo Cristofori of Padua, because the keys could be struck softly or loudly using the foot pedals. The piano part stuck—the forte was eventually dropped.

Latin *clavis* evolved into French *clef*, contributing those friendly signs at the beginning of sheet music, the C, G, and F **clefs** (keys to the music). Furthermore, the French term for a novel whose characters are thinly-veiled parodies of real people is **roman a clef**—a novel with a key.

A **fugue** is a musical composition in which successive melodic themes are repeated in contrapuntal fashion. It derives from Latin *fugere* 'to flee', as in *The Fugitive*. The serial voices seem to flee from each other (or chase each other depending on your perspective). In psychiatry a **fugue** state is one of amnesia—a state in which memory seems to "flee the intellect."

All of which should prove radical to the discerning mind. ■

Book Reviews

A Consumer's Guide to Aging. David H. Solomon, M.D., Elyse Salend, M.S.W., Anna Nolen Rahman, M.S.W., Marie Bolduc Liston, M.S.W., and David B. Reuben, M.D. The Johns Hopkins University Press. 1992. 526 pages. Hard cover, \$45.00; soft cover, \$22.95.

Recognized as leaders in their sphere of geriatrics, the authors of this book are well qualified to offer guidance for the elderly. In 1984, they launched the newspaper column "On Aging," which was syndicated by the Washington Post Writers' Group. Reaching more than six million households, the column generated a multitude of questions as readers sought advice on problems they were encountering in the later years of life. This book, a distillate of the authors' sound opinions, can serve as a *vade mecum* for the older population.

The authors believe that longevity is a less important measure of aging than the degree of bodily degeneration made evident during the life span. Arguing that the rate of degeneration is greatly influenced by controllable habits, they provide sound advice on fitness, health problems, emotional balance, finances, insurance, home, family, intimacy, workplace, and leisure.

All topics are adequately and tastefully addressed. Most chapters include lists of references and recommended reading, and the book includes three appendixes and an excellent index. In addition, aware that the book's reading population would be drawn mostly from the elderly, the designer created an over-sized volume with type three points larger than usual and generous spaces between the words and lines.

Is there a place for such a book in our present society? The answer must be an emphatic "Yes." During this century, the life span in the United States increased by 28 years, or 60%. In 1990, the U.S. population numbered close to 249 million. Almost 12.5% were over age 65: 18

million were ages 65 to 74, 10 million were ages 75 to 84, and 3 million were age 85 or older.

Almost five million elderly people, however, live in poverty, a problem gently satirized by Jonathan Swift in *Gulliver's Travels*. In a report of his voyage to Luggnag, Gulliver describes the plight of the Struldbruggs—the immortals—who lose their property at age 80 and are supported miserably by money from their estates or by the government. They become opinionated, morose, and talkative, but incapable of making friends. They have counterparts in our society, some of whom may avoid such a fate if they receive proper advice.

A Consumer's Guide to Aging highlights this defect in our society and seeks to provide a remedy. Although the poor may obtain the volume from a library, they will be only partially able to use its advice; they are more concerned with obtaining food than keeping fit. Older men and women with few financial concerns, however, will profit from reading it.

This semi-medical book should have wide popular appeal and should appear on the shelves of all libraries. Physicians with even a small geriatric practice should be familiar with the valuable advice it provides for elderly patients. All men and women over age 65 should thoughtfully consider purchasing the book if their circumstances allow. After an initial reading, they will find it to be a continuous guide to more fruitful and contented lives.

JOSEPH M. MILLER, M.D.
Timonium, Maryland ■

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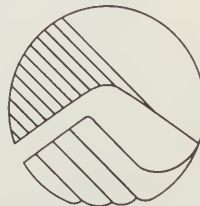
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170.0 - 170.9

198.5

199.0, 199.1

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The following revisions have been made to the **Chemotherapeutic Drug Coverage** policy:

- 1. The ICD.9.CM codes for liver cancer have been corrected.
- 2. Endometriosis has been added as an appropriate diagnosis (617.0 - 617.9) under Goserelin Acetate (Zoladex) effective for dates of service on and after 2/2/93.
- 3. Mesna has been moved from page 11 to page 10.
- 4. Multiple myeloma has been added to methotrexate - J9250, J9260. It was inadvertently left off.
- 5. Pentostatin - J9999, Proleukin - J9999 and Taxol - J9999 have been added (with appropriate diagnoses). These were inadvertently left off.
- 6. Please note: Lupron, Neupogen (Filgrastim) and Leukine (Sargramostim) have been deleted from this policy. These are not chemotherapy agents. Separate policies are being developed, i.e., see draft policy on Colony Stimulating Factors.
- 7. The diagnosis codes have been corrected for: liver cancer, trophoblastic germ cell choriocarcinoma, colorectal cancer and others.

Barry S. Gold M.D.

Approved by: Barry S. Gold, M.D., F.A.C.P,
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1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

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• **Editorial responsibility**—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset.

Miscellaneous meetings

Trials and Deliberations in Medicine, . Attendants receive a 5% discount on 1995 Med Mutual renewal premiums and 2 Cat 1 AMA/PRA credits. Fee: \$40.00. Info: Toni Davis or Natalie Harper at 410-785-0050:

| | |
|---|----------|
| Medical Mutual, Hunt Valley | June 1 |
| P.G. Hospital Center, Cheverly | June 2 |
| Harbor Hospital, Baltimore | June 8 |
| Medical Mutual, Hunt Valley | June 14 |
| St. Mary's Hospital, Leonardtown | June 15 |
| Med Chi, Baltimore | June 16 |
| Shady Grove Hospital, Rockville | June 22 |
| Carroll Co. General Hospital, Westminster | June 28 |
| Columbia Conference Center, Columbia | June 30 |
| Suburban Hospital, Bethesda | July 5 |
| Memorial Hospital, Cumberland | July 6 |
| Peninsula General Hospital, Salisbury | July 7 |
| Medical Mutual, Hunt Valley | July 14 |
| Montgomery General Hospital, Olney | July 20 |
| Medical Mutual, Hunt Valley | July 26 |
| Patuxent Medical Group, Columbia | July 28 |
| Ramada Inn, Hagerstown | Aug. 4 |
| Medial Mutual, Hunt Valley | Aug. 9 |
| Med Chi, Baltimore | Aug. 16 |
| Kent/Queen Anne's Hosp., Chestertown | Aug. 18 |
| Shady Grove Hospital, Rockville | Aug. 23 |
| Conference Center, Columbia | Aug. 24 |
| Liberty Medical Center, Baltimore | Aug. 25 |
| Medical Mutual, Hunt Valley | Aug. 30 |
| Patuxent Medical Group, Columbia | Sept. 1 |
| Harford Memorial, Havre de Grace | Sept. 6 |
| Medical Mutual, Hunt Valley | Sept. 7 |
| Anne Arundel Med. Ctr., Annapolis | Sept. 8 |
| Medical Mutual, Hunt Valley | Sept. 12 |
| Doctor's Comm. Hosp., Lanham | Sept. 13 |
| Holy Cross Hosp., Silver Spring | Sept. 20 |
| Medical Mutual, Hunt Valley | Sept. 21 |
| Frederick Memorial, Frederick | Sept. 22 |

Aggressive management of cardiovascular emergencies: Featuring the role of echocardiography, sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. June 1-3

Modern advances in the treatment of pain, sponsored by the Baltimore City Medical Society, at St. Agnes Hospital, in Baltimore, Maryland. 1 Cat 1 AMA/PRA credit. Fee: free. Info: 410-625-0022. June 2

Miscellaneous meetings (continued)

| | |
|---|-------------------|
| Obstetrics dilemmas in the era of managed health care , sponsored by the Eastern Virginia Medical School, at the Sheraton Inn Oceanfront, in Virginia Beach, Virginia. Cat 1 AMA/PRA credits available. Info: Jeanette Schmitz, 804-446-6143. | June 3-4 |
| Pediatric cardiology update , sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. | June 6-8 |
| The management of drug induced disease: How health care professionals and the FDA can work together to reduce the risks of adverse drug events , at the Georgetown University School of Medicine, Pre-clinical Science Building Auditorium. 8 Cat 1 AMA/PRA credits. Info: 301-443-2200 or 202-687-1600. | June 10 |
| Third international hands-on ERCP conference , sponsored by Education Design, course director, Dr. Mark D. Noar at the Baltimore Inner Harbor Marriott. 24 Cat 1 AMA credits available. Fee: \$1500 Didactic & lab, \$550 Didactic only. Info: Susan Hamer 410-494-0160. | June 10-12 |
| Cardiovascular pharmacology-1994 , sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. | June 9-11 |
| Intensive review of internal medicine , sponsored by the George Washington University Medical Center, at the Washington Marriott, Washington, DC. Info: Todd Belfield, 202-994-4285. | June 11-14 |
| Second annual board review in family medicine , sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, in Arlington, Virginia. Info: Daniel Reichard, 202-994-4285. | June 11-15 |
| The medical & surgical treatment of macular disorders , sponsored by the University of Maryland School of Medicine and the Retina Institute of Maryland, at the Marriott, in Annapolis, Maryland. 6 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$100 fellows and allied health professionals. Info: 410-337-4500. | June 17 |
| 10th annual meeting of the International Society of Technology Assessment in Health Care , sponsored by the George Washington University Medical Center, at Stouffer Harborplace, Baltimore, Maryland. Info: Maria Gorrick, 202-994-4285. | June 19-22 |
| Exercise expired gas analysis, nuclear cardiology, and echocardiography: the noninvasive assessment of ischemic heart disease , sponsored by the American College of Cardiology at the Heart House Learning Center in Bethesda, MD. Info: 800-257-4737. | June 22-24 |
| First annual meeting of the Southern Association for Faculty Practice , Williamsburg, VA. Cat 1 AMA credits available. Info: 800-945-1840. | June 23-25 |
| Twelfth summer symposium in internal medicine , sponsored by the Eastern Virginia Medical School, at the Holiday Day on the Ocean, Virginia Beach, Virginia. 15.5 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$195 resident, nurse, allied health. Info: Ann McClanahan, 804-446-6141. | June 24-26 |
| Annual meeting of the Bolivian Medical Society , sponsored by the George Washington University Medical Center, in Arlington, Virginia. Info: Todd Belfield, 202-994-4285. | Aug. 4-7 |
| Women's health research topic , sponsored by the Baltimore City Medical Society at the Montebello Rehabilitation Hospital. 1 Cat 1 AMA Credit, Fee: Free. Info: 410-625-0022. | Sept. 1 |

Miscellaneous meetings (continued)

- | | |
|---|-------------------|
| Diabetic retinopathy: A Comprehensive review and update , sponsored by The American Diabetes Assoc. and The Retina Institute of MD, at the Stouffers Harborplace Hotel, Baltimore. 7.5 Cat 1 AMA Credits. Fee: \$275/physicians, \$100.00/fellows, residents, and allied health professionals. Info: 410-337-4500. | Sept. 23 |
| Hematology board review course , sponsored by the George Washington University Medical Center, at the Ritz-Carlton, in Pentagon City, Virginia. Info: Maria Gorrick, 202-994-4285. | Oct. |
| Network approach to provision of health care , sponsored by the Baltimore City Medical Society at the Good Samaritan Hospital. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. | Oct. 6 |
| Psycho-economics: clinical psychiatry and health care reform in the 1990s , sponsored by the American Psychiatric Association, in Baltimore, Maryland. 34 Cat 1 AMA/PRA credits. Info: 202-682-6174. | Oct. 8-12 |
| Second annual gynecology CME course , at the Plaza Hotel in NY, 13.5 Cat 1 AMA credits. Fee: \$495/physicians; \$295/physicians-in-training and allied health professionals. Info: Svetlana Lisanti, 201-385-8080. | Oct. 15-17 |
| Annual business meeting , sponsored by the Baltimore City Medical Society at UMMS Davidge Hall. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. | Nov. 3 |

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month; 8:00-9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, Maryland. Info: 301-279-6115.

| | |
|--|---------|
| Tumor conference | June 9 |
| Ischemic heart disease | June 16 |
| Current therapy of obesity | June 23 |
| Palliative care across the disease spectrum | June 30 |
| Dermatosis of pregnancy | July 7 |
| Tumor conference | July 14 |
| Recent perinatal advances in the evaluation of the fetus | July 28 |

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

- | | |
|---|------------------|
| 21st century retina: what's hot, hype, and hard fact. 8 Cat 1 AMA/PRA credits. Fee: \$225 physicians; \$100 residents, fellows, and allied health professionals. | June 10 |
| The seventh summer institute on environmental health sciences. Cat 1 AMA/PRA credits available. Info: Denis Barton, 410-955-3537 or Kay Castleberry, 410-955-2212. | June 6-17 |

The Johns Hopkins Medical Institutions (continued)

| | |
|--|-------------------------------|
| Principles and practices of data management for clinical trials. Cat 1 AMA/PRA credits available. Fee: TBA. | June 16-17 |
| Advanced pediatric life support courses. 20 Cat 1 AMA/PRA credits; 18.5 AAFP prescribed hours; 20 AAP credit hours; 17 ACEP Cat 1 credits. Fee: \$525. | June 13-15 |
| Johns Hopkins third annual update on obstetric anesthesia plus an optional fiberoptic airway management workshop. 12 Cat 1 AMA/PRA credits. Fee: \$275 physicians; \$75 residents and fellows; one-day fees available. | Aug. 13-14 |
| Ophthalmology for the pediatrician, Cat 1 AMA credits available. Fee: \$125/physicians; \$95/residents, fellows and allied health professionals. | Sept. 16 |
| Airway management: Hands-on workshops, case management colloquia, and difficult airway/intubation alert. Cat 1 AMA/PRA credits available. Fee: \$650. | Sept. 23-25 |
| Pediatrics for Practitioner update '94, 14 Cat 1 AMA credits. Fee: \$290/physicians; \$190/residents*, retired physicians, allied health professionals, fellows* (with letter). | Sept. 29-30 |
| 20th anniversary: Annual topics in gastroenterology and liver disease. Cat 1 AMA/PRA credits available. Fee: \$495 physicians; \$250 residents and fellows (with letter from department chairperson verifying status). | Oct. 5-7 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA/PRA credits available. Fee: \$500 lectures; \$400 each additional lab; \$200 lectures for fellows and allied health professionals. | Oct. 24-26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27-30 |
| Advanced pediatric life support courses, 20 Cat 1 AMA credits. Fee: \$525. | Oct. 31-Nov. 2; June 12-14 |

Continuously throughout the year

| | |
|---|--|
| Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600. | |
| The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169. | |
| Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500. | |
| Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988. | |
| Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600. | |

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Managing emergency medical services, at the University of Maryland Baltimore County. **July 5-29**
Info: Dr. Richard Bissell 410-455-3776.

R. Adams Cowley 16th annual national trauma symposium, at the Hyatt Regency, in **Nov. 16-20, 1994**
Baltimore, Maryland. Info: 410-328-2399.



PHYSICIAN'S RECOGNITION AWARD

During March and February 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Frank J. Ayd, M.D.
Diane L. Colgan, M.D.
Robert A. Cordes, M.D.
Salvador J. Cosimano, M.D.
Fredric D. Daniell, M.D.
Michael R. Dobridge, M.D.
Oscar A. Farias, M.D.
George T. Grace, M.D.
Douglas M. Grodin, M.D.
Kenneth P. Judd, M.D.
Paula R. Kaiser, M.D.
Ronald A. Katz, M.D.
Marshall P. Keys, M.D.
Fauzi Khalil, M.D.
Michael K. Kowalski, M.D.
Morton A. Kress, M.D.
Harvey A. Lewis, M.D.
Marilyn D. Miller, M.D.
Judd W. Moul, M.D.
Joseph C. Orlando, M.D.

Manoochehr Pooya, M.D.
John M. Ratino, M.D.
James E. Vogel, M.D.
Sandra L. Welner, M.D.
Jean M. Welsh, M.D.
Robert J. Wilensky, M.D.
Charles H. Winnacott, M.D.
Anthony T. Amabile, M.D.
Bruce W. Berger, M.D.
Jayson M. Berger, M.D.
Vincent H. Bono, M.D.
Harold J. Campbell, M.D.
Alain G. Champaloux, M.D.
Barbara Jean Crain, M.D.
Wilhelmina M. Cruz, M.D.
Herman J. Flax, M.D.
Robert L. Flynn, M.D.
Mary Louise S. Furth, M.D.
Ramon L. Gonzalez, M.D.
Roger L. Gordon, M.D.

Richard L. Gross, M.D.
William J. Jaffurs, M.D.
Matthew A. Kalman, M.D.
Thomas L. Koury, M.D.
Chul Soo Kwon, M.D.
Robert D. Lamport, M.D.
Albert K. Lee, M.D.
Norman C. Lyster, M.D.
Thomas H. Magee, M.D.
Stanley E. Order, M.D.
George M. Orr, M.D.
Kadan C. Sau, M.D.
Frederic T. Schwartz, M.D.
Nathan A. Scott, M.D.
Bhupinder K. Singh, M.D.
Larry A. Snyder, M.D.
Joseph M. Solinas, M.D.
Sanjiv Sood, M.D.
Donald C. Walton, M.D.

We Agree.

Every state medical society, 64 medical specialty societies, and the American Medical Association agree that any health system reform legislation must contain the principles outlined in the letter below:

February 23, 1994

Dear Senator/Representative;

As physician organizations, we agree on the need for health system reform legislation that gives every American universal coverage for health care and effectively controls rising health costs, while ensuring quality patient care. These principles have been articulated by numerous medical organizations in their various health system reform policies and proposals. They remain the foundation of our legislative agenda, which is to enact laws that assure universal coverage for a standard set of health benefits, regardless of employment or economic status.

We believe that any measure adopted by the Congress should:

- Achieve universal coverage through a program where responsibility is shared by employers, individuals, and government in paying for health care coverage.
- Assure that every American has his/her choice of health plans, physicians, and other providers.
- Establish competition in the marketplace as a method of slowing the rate of growth in health spending.
- Give patients price and quality information to permit them to make informed decisions.
- Eliminate needless bureaucracy to create an efficient, streamlined, and coordinated system that minimizes red tape for patients, physicians, and other providers. Furthermore, health system reform must leave medical decision-making in the hands of physicians and their patients.

We believe that to enable physicians to best serve the interests of their patients, meaningful health system reform also must contain these elements:

- Significant antitrust relief that enables physicians to have a strong voice to balance the growing corporate and government domination of health care.
- Allow for physician-directed health care networks.
- Enhanced self-regulatory powers that would enable the profession to effectively police itself and its members without the threat of unwarranted litigation.

We also believe that major reforms in the professional liability system must be enacted, including a \$250,000 cap on non-economic damages, limits on plaintiff attorneys' fees, and other measures that would minimize defensive medicine.

Every American will be affected by this legislation. The focus of policy-makers should be on how their decisions will affect patient care. Any system that raises significant barriers between patients and physicians will not provide the quality care our nation expects and deserves. We believe the above principles outline a framework for establishing constructive, effective, and needed health system reform.

Join your colleagues in your county and state medical societies and the AMA. And stand with the organizations that stand behind you.

American Medical Association
Physicians dedicated to the health of America



Aerospace Medical Association
Medical Association of the State of Alabama
Alaska State Medical Association
American Academy of Child & Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic & Reconstructive Surgery
American Academy of Family Physicians
American Academy of Insurance Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology — Head & Neck Surgery
American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American Association of Clinical Urologists, Inc.
American Association of Electrodiagnostic Medicine
American Association of Neurological Surgeons
American College of Allergy and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Legal Medicine
American College of Medical Quality
American College of Nuclear Medicine
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Rheumatology
American Fertility Society
American Gastroenterological Association
American Group Practice Association
American Medical Association
American Medical Directors Association
American Orthopaedic Association
American Orthopaedic Foot and Ankle Society
American Pediatric Surgical Association
American Psychiatric Association
American Roentgen Ray Society
American Society of Abdominal Surgeons
American Society of Addiction Medicine, Inc.
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Clinical Pathologists
American Society of Colon and Rectal Surgeons
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society of Hematology
American Society of Internal Medicine
American Society of Maxillofacial Surgeons
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American Society for Therapeutic Radiology and Oncology
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Idaho Medical Association
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Medical & Chirurgical Faculty of the State of Maryland
Massachusetts Medical Society
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Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Radiological Society of North America
Renal Physicians Association
Rhode Island Medical Society
Society for Cardiovascular and Interventional Radiology
Society of Critical Care Medicine
Society for Investigative Dermatology, Inc.
Society of Nuclear Medicine
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont State Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
State Medical Society of Wisconsin
Wyoming Medical Society

William Donald Schaefer - Governor of Maryland



EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

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Nelson J. Sabatini - Secretary
Department of Health & Mental Hygiene

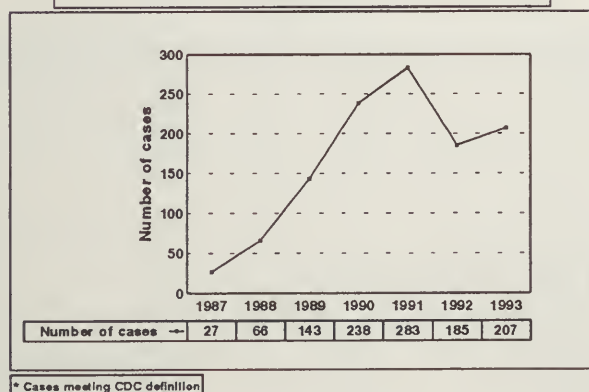
J. Mehzen Joseph, PhD - Director
Community Health Surveillance & Laboratories Admin

Ebenezer Israel, MD, MPH- Director
Epidemiology & Disease Control Program

May, 1994 Lyme Disease in Maryland, 1993

The trend of Lyme disease in Maryland from 1987 to 1993 is shown in Figure 1. In 1993, every jurisdiction reported cases. The number of cases and incidence rates per 100,000 population by jurisdiction in 1990, 1991, 1992, and 1993 are shown in Table 1.

Figure 1. Lyme Disease Confirmed Cases* 1987-1993



Seventy-seven percent of the 207 cases had onset of illness in April through September; the peak incidence was in June (56 cases) and July (44 cases) (Figure 2).

Figure 2. 1993 Lyme Disease Confirmed Cases* by date of onset of symptoms

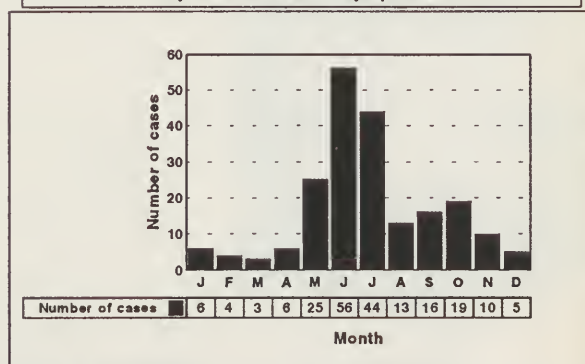
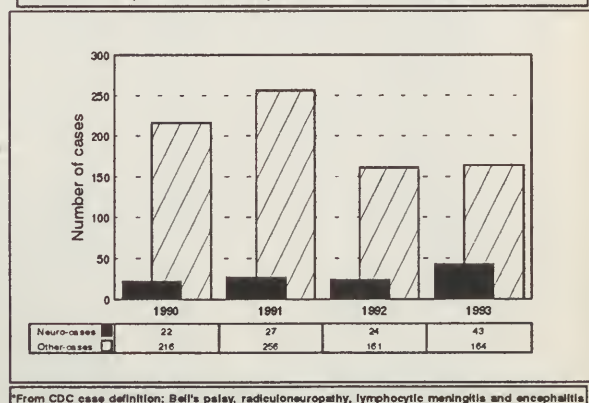


Figure 3. Neurological manifestations* in Lyme disease confirmed cases reported to the Maryland DHMH during 1990-93.



The male to female ratio was 1.2:1.0. Among the cases with known race, 176 (88.9%) were white, 15 (7.6%) black, and

7 (3.5%) were other races. Ages ranged from 2 to 86 years (median age was 33 years).

A definite tick bite prior to onset of illness was reported by 77 (37.2%) cases, but 84 cases (40.6%) reported no tick exposure.

Of the 207 cases, 125 (60.4%) had erythema migrans, 55 (26.6%) had arthritis, 27 (13.0%) had Bell's palsy, 13 (6.3%) had radiculoneuropathy, 7 (3.4%) had cardiac symptoms, 5 (6.3%) had lymphocytic meningitis, and 4 (1.9%) had encephalitis. Figure 3 shows the number of cases reported to have neurological manifestations. The percent of cases

reported with neurologic manifestations has increased from 9.2% in 1990 to 20.8% in 1993. The ages of the Lyme disease cases reported to have neurological manifestations between 1990 and 1993 is shown in Figure 4.

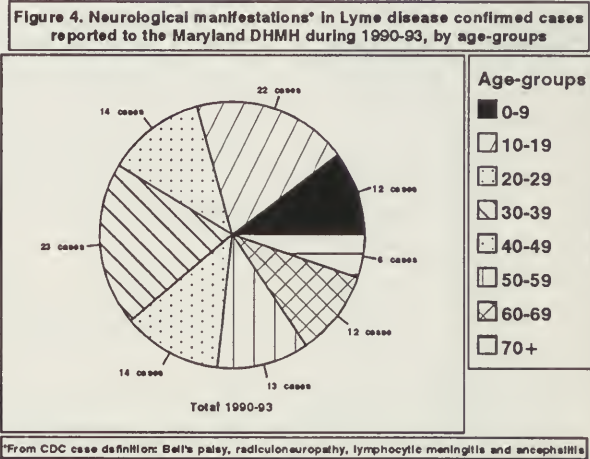


Table 1. Lyme Disease in Maryland, 1990-1993

| Jurisdiction | 1990 | | 1991 | | 1992 | | 1993 | |
|------------------|------|-------|------|------|------|------|------|------|
| | N | Rate* | N | Rate | N | Rate | N | Rate |
| Allegany | 1 | 1.3 | 1 | 1.3 | 0 | 0.0 | 1 | 1.4 |
| Anne Arundel | 27 | 6.3 | 22 | 5.1 | 8 | 1.8 | 10 | 2.2 |
| Baltimore City | 12 | 1.6 | 10 | 1.4 | 10 | 1.4 | 6 | 0.8 |
| Baltimore County | 39 | 5.6 | 49 | 7.0 | 35 | 5.0 | 57 | 8.1 |
| Calvert | 7 | 13.6 | 4 | 7.5 | 6 | 10.9 | 4 | 7.0 |
| Caroline | 3 | 11.1 | 22 | 80.2 | 16 | 57.8 | 8 | 28.2 |
| Carroll | 5 | 4.1 | 4 | 3.1 | 2 | 1.5 | 6 | 4.5 |
| Cecil | 15 | 21.0 | 30 | 37.6 | 11 | 13.6 | 18 | 24.0 |
| Charles | 23 | 22.7 | 10 | 9.7 | 11 | 10.3 | 10 | 9.0 |
| Dorchester | 1 | 3.3 | 5 | 16.3 | 4 | 13.0 | 4 | 13.2 |
| Frederick | 3 | 2.0 | 2 | 1.3 | 0 | 0.0 | 1 | 0.6 |
| Garrett | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 3.5 |
| Harford | 27 | 14.8 | 18 | 9.8 | 13 | 7.0 | 11 | 5.6 |
| Howard | 10 | 5.3 | 7 | 3.7 | 3 | 1.6 | 8 | 3.8 |
| Kent | 9 | 50.4 | 12 | 69.9 | 14 | 81.3 | 7 | 38.5 |
| Montgomery | 13 | 1.7 | 11 | 1.5 | 6 | 0.8 | 8 | 1.0 |
| Pr. George's | 10 | 1.4 | 8 | 1.1 | 8 | 1.1 | 10 | 1.3 |
| Queen Anne's | 10 | 29.5 | 27 | 79.6 | 17 | 48.7 | 18 | 49.0 |
| Saint Mary's | 5 | 6.6 | 14 | 18.7 | 6 | 7.9 | 2 | 2.5 |
| Somerset | 0 | 0.0 | 2 | 8.7 | 4 | 17.4 | 1 | 4.0 |
| Talbot | 1 | 3.3 | 4 | 13.7 | 5 | 16.9 | 9 | 28.0 |
| Washington | 3 | 2.5 | 0 | 0.0 | 0 | 0.0 | 1 | 0.8 |
| Wicomico | 6 | 8.1 | 6 | 7.9 | 2 | 2.6 | 3 | 3.9 |
| Worcester | 8 | 22.2 | 15 | 38.5 | 4 | 10.1 | 3 | 8.3 |
| TOTAL | 238 | 5.0 | 283 | 5.9 | 185 | 3.9 | 207 | 4.2 |

*Rate per 100,000 population

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The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral Street
Baltimore, MD 21201
410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a résumé to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

MMJ announcements for physician placements in the classified advertisements are charged at the regular classified advertising rate.

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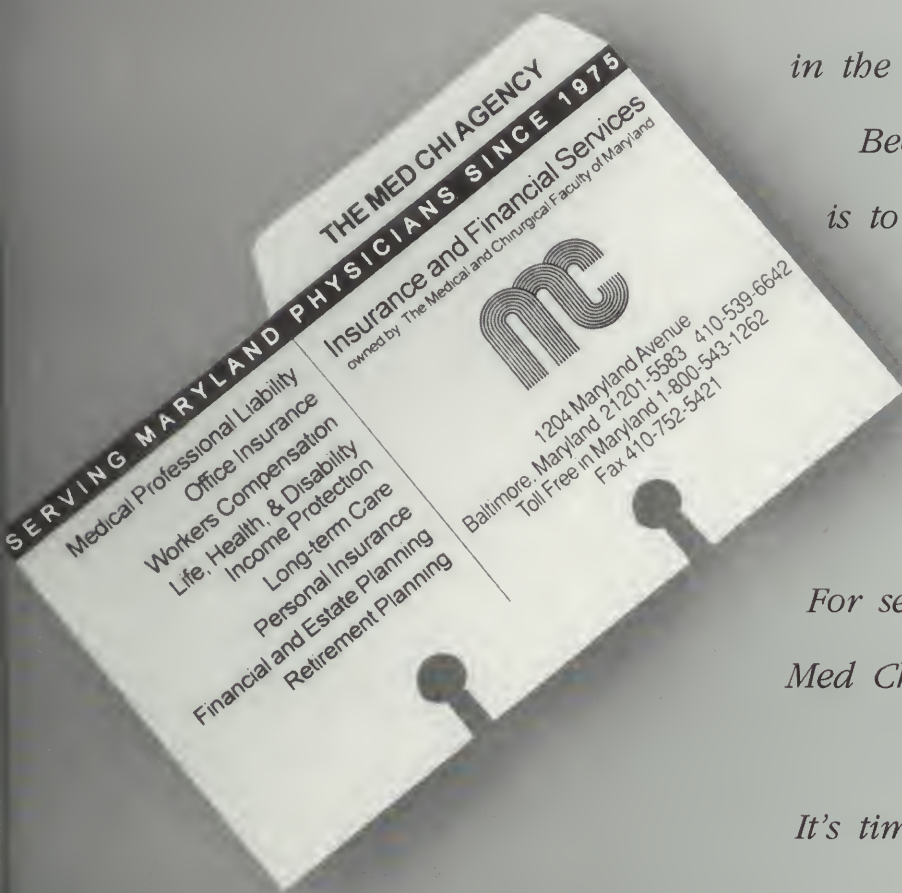
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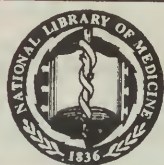


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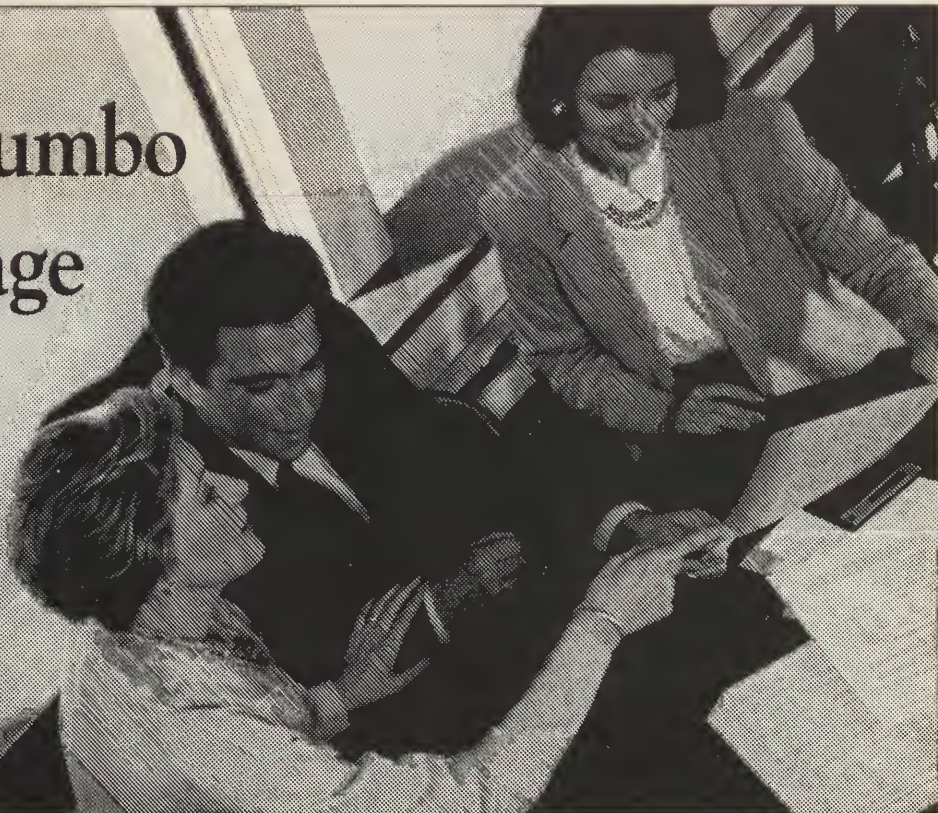
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the 1994
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Dr. Yamamota... "What medical care can be provided at home?"

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Dr. Yamamota... "Can Kirson supply home oxygen equipment?"

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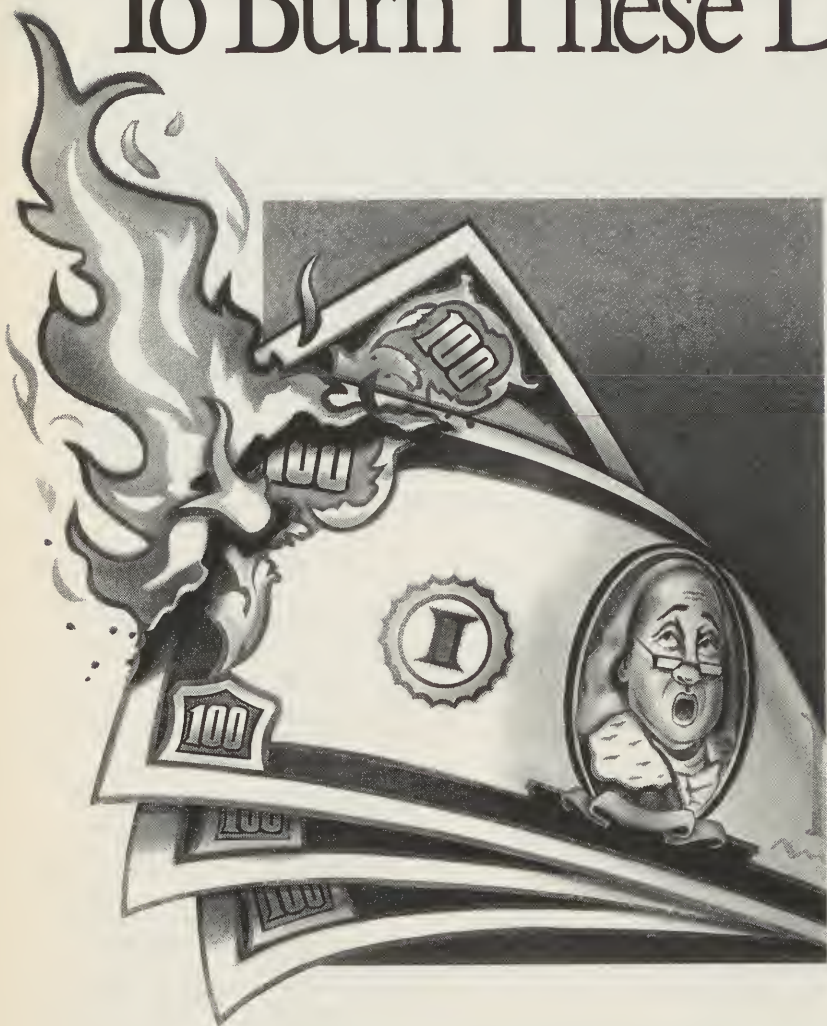
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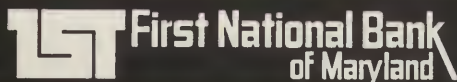
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Council Chairpersons Selected

The following Med Chi physicians have been selected to serve as council chairpersons for 1994-1995:

Bylaws - Gary L. Rosenberg, M.D.
Ethical and Judicial Affairs - Marianne Benkert, M.D.
Medical Education - Henry Wagner, M.D.
Scientific Affairs - Martin P. Wasserman, M.D.
Medical Services - Sheldon Goldgeier, M.D.
Legislation - Hilary T. O'Herlihy, M.D.
Medical Affairs - Michael A. Berman, M.D.
Planning and Development - Jack C. Gordon, M.D.

Blue Cross and Blue Shield of Maryland to Discontinue Service of Medicare Part B Contract

Blue Cross and Blue Shield of Maryland (BC/BS of MD) announced that it would discontinue the Medicare Part B contract at the end of its current term. The Medicare Part B contract covers beneficiaries for provider services. The insurer and the Health Care Financing Administration (HCFA) agreed to work together for an orderly transition to a replacement carrier to minimize confusion. BC/BS of MD will continue to administer the Part A portion of Medicare as it has since the Medicare program began in 1966. Part A covers hospital services for beneficiaries. The company will examine Part A business in relation to any future changes HCFA may make.

The new contractor for Maryland Medicare Part B claims, excluding Montgomery and Prince George's counties, is Texas Blue Cross Blue Shield.

Montgomery and Prince George's counties will remain under Pennsylvania Blue Shield.

Med Chi will be part of the transition team that HCFA plans to set up to effectuate a smooth transition to the new Medicare carrier. Information about the transition will be forthcoming to the membership.

1994 Med Chi Semiannual Meeting

The 1994 Med Chi Semiannual Meeting will be held Friday, September 9 through Sunday, September 11, 1994, at the Sheraton Ocean City Resort and Conference Center in Ocean City, Maryland.

Med Chi has reserved a block of rooms at a special group rate of \$114.00 per night for a single/double occupancy room (tax and incidentals not included). To reserve a room, call the Sheraton at 1-800-638-2100 and tell them you will be attending the Med Chi meeting. Please reserve early — reservation deadline is August 25, 1994, but rooms may fill prior to this date.

Mediating Medical Opinion: Strategies for Resolving Conflict

Med Chi invites you to join renowned healthcare negotiation expert, Leonard J. Marcus, Ph.D., on Wednesday, July 20, 1994, for "Mediating Medical Opinion: Strategies for Resolving Conflict," an important one-day workshop that builds the non-adversarial negotiation skills necessary for today's medical practice.

This seminar, sponsored by Med Chi in association with AMA Financing & Practice Services, Inc. (a subsidiary of the American Medical Association), is being held at Med Chi, 1211 Cathedral Street, from 8:00 a.m. - 5:00 p.m.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for 7 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor Continuing Medical Education (CME) for physicians.

Registration is \$50 for Med Chi members and \$75 for nonmembers. For a registration form, or additional information, call Joan Mannion at 410-539-0872 or 1-800-492-1056.

***Med Chi Seeks
Physicians for Sunday
Rounds Radio
Program***

Sunday Rounds is a weekly radio program, hosted by John Stupak and sponsored by Med Chi, that airs Sunday evenings on WBJC (91.5 FM) from 7:00 p.m. - 8:00 p.m. Med Chi physicians are invited to participate in this program, which is aimed at providing the public with information on current health topics. If you are interested in being a guest on *Sunday Rounds*, please call Heather Johnson at 410-539-0872, ext. 306.

Sunday Rounds Schedule

Date: July 3, 1994
Guest: Bonnie Epstein, M.D.
Topic: Dermatology

Date: July 17, 1994
Guest: Michael Levin, M.D.
Topic: HIV and Aids

Date: July 31, 1994
Guest: Albert Blumberg, M.D.
Topic: Cancer

Date: August 14, 1994
Guest: Myron Murdock, M.D.
Topic: Urology, male fertility
difficulties

Date: August 28, 1994
Guest: Donald Stepita, M.D.
Topic: Cosmetic surgery

Date: September 11, 1994
Guest: Mark Diamond, M.D.
Topic: Digestive and liver
diseases

Date: September 25, 1994
Available

Date: October 9, 1994
Available

Date: October 23, 1994
Guest: Carol Jack Scott, M.D.
Topic: Domestic violence

Date: November 6, 1994
Guest: William Stern, M.D.
Topic: Digestive diseases and
ulcers

Date: November 20, 1994
Available

Date: December 4, 1994
Available

Date: December 18, 1994
Available

***Mark Your Calendars -
Upcoming Meetings***

Next meeting of the Med Chi House of Delegates - July 21, 1994 (at Med Chi)

Next meeting of the Med Chi Board of Trustees - August 11, 1994 (at Med Chi)

Physicians who provide covered Medicare services to any rural or urban HPSA are entitled to an incentive payment of ten percent of the amount paid by Medicare for the service. The Maryland HPSAs are:

Rural HPSAs

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|--------------------------------|-------------------------|
| Caroline County | Worcester County Parts: |
| Dorchester County Parts: | Snow Hill/Pocomoke |
| Northeast Dorchester (Hurlock) | District 1 (Pocomoke) |
| District 1 (Fork) | District 2 (Snow Hill) |
| District 2 (East New Market) | District 7 (Atkinsons) |
| District 3 (Vienna) | District 8 (Stockton) |
| District 12 (Williamsburg) | |
| District 15 (Hurlock) | |

Urban HPSAs

(Note: Some HPSAs are defined by census track (C.T.) numbers.)

Allegany County

| | |
|--------------------|----------------------|
| Hancock (MD/PA/WV) | District 1 (Orleans) |
|--------------------|----------------------|

Anne Arundel County

| | | |
|------------|-----------|-----------|
| Owensville | | |
| C.T. 7012 | C.T. 7013 | C.T. 7014 |
| C.T. 7070 | C.T. 7080 | |

Baltimore City

North Central Baltimore

| | | |
|----------|-----------|----------|
| C.T. 805 | C.T. 901 | C.T. 902 |
| C.T. 903 | C.T. 904 | C.T. 905 |
| C.T. 906 | C.T. 907 | C.T. 908 |
| C.T. 909 | C.T. 1204 | |

Donnell Heights

| | |
|--------------|--------------|
| C.T. 2606.01 | C.T. 2606.02 |
|--------------|--------------|

West Baltimore

| | | |
|-----------|-----------|-----------|
| C.T. 1801 | C.T. 1802 | C.T. 1803 |
| C.T. 1901 | C.T. 1902 | C.T. 1903 |
| C.T. 2001 | C.T. 2002 | C.T. 2003 |
| C.T. 2004 | C.T. 2005 | |

Orleans Square

| | | |
|----------|-------------|----------|
| C.T. 103 | C.T. 105 | C.T. 201 |
| C.T. 202 | C.T. 602 | C.T. 603 |
| C.T. 702 | C.T. 703 | C.T. 704 |
| C.T. 802 | C.T. 803.01 | C.T. 804 |
| C.T. 806 | C.T. 807 | C.T. 808 |

Washington County

| | |
|----------------------|-----------------------------|
| Hancock (MD/PA/WV) | District 15 (Indian Spring) |
| District 5 (Hancock) | |

To determine if your services will be rendered in an urban HPSA census tracking area, physicians may call the Professional Relations Representatives at 561-4058.

ACGME Ruling

The U.S. Court of Appeals overturned a lower court decision which blocked the Accreditation Council for Graduate Medical Education from withdrawing accreditation from a Pennsylvania hospital's general surgery residency program. The appellate court in *McKeesport v. the ACGME*, stated that the "ACGME's withdrawal of the program was not state action." Furthermore, the court rejected the argument that the ACGME residency standards were vague and led to arbitrary decision making, and they rejected the contention that due process had not been available. The AMA filed an amicus curiae brief in this case.

Patient Protection Act

The AMA has proposed legislation that would require health plans to outline quality and cost-control standards to patients and physicians and would give doctors various contracting protections.

The Patient Protection Act provides that insurers are required to give patients:

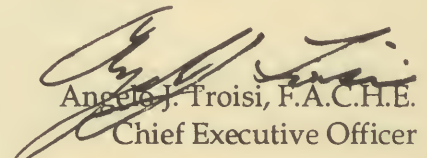
- a list of covered and excluded services;
- clear instructions on preauthorization review and other UR requirements;
- an explanation of how coverage limits and UR affect them;
- survey data on the plan's patient satisfaction rate;
- three coverage options: managed care, traditional indemnity insurance or a benefit-payment schedule; and
- access to a point-of-service plan.

The Patient Protection Act provides that insurers are required to give doctors:

- a voice in medical policymaking and quality standards;
- quality-based credentialing criteria;
- due process rights and protection from termination without cause; and
- access to UR criteria.

Physicians can send a Western Union message to Maryland's Senators and their Congressional Representative asking them to support the Patient Protection Act by calling 1-800-354-9292. The Western Union operator will make sure that your elected representatives receive your message. Your cost for all three messages will be \$8.25, which can be billed to your phone number or your VISA or MasterCard account.

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Angelo J. Troisi, F.A.C.H.E.
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Whose eponym? The case for Edward Selleck Hare, M.R.C.S.

Dr. Bart Gershen¹ uses well the lines from Shakespeare's *King John*:

And if his name be George
I'll call him Peter
For new-made honor doth forget
men's names

The statement is particularly true for the unrecognized and almost forgotten individual who first described the Pancoast and Horner syndromes. The eponyms give to these men, however, what perhaps belongs to another.

In 1924, Pancoast^{2,3} described a peculiar syndrome, originating from a neoplasm, as a specific entity occurring at the apex of the lung to produce a characteristic group of signs and symptoms. He called the condition the "superior sulcus syndrome." Although at first he considered it to be pleural in origin, he later considered the new growth to arise from the fifth bronchial pouch.

Later studies demonstrated that a number of other conditions could produce the symptom complex of homolateral shoulder and arm pain and cervical sympathetic paralysis. These conditions included trauma and neoplasms of the lung, spinal cord, meninges, cervical vertebrae, or ribs.

Cervical sympathetic paralysis alone may be caused by tumors of the neck, aneurysm, enlarged lymph nodes, mediastinal neoplasm, tuberculosis, and trauma.

In 1869, Horner,⁴ in a brief contribution to a German journal of ophthalmology, described a 40-year-old patient with headaches and a drooping right upper eyelid. The right pupil was smaller than the left, but reacted to light. The right side of the face was flushed and dry, in contrast to the left, which remained pale and cool. Horner did not review the previous literature (François Poufir du Petit and Claude Bernard had described the eye changes in animals and human beings,⁵ respectively), but merely submitted a simple case report.

Forgotten or overlooked, however, is the contribution of Edward Selleck Hare,⁶ made in 1838. He described a patient in whom physiologic and pathologic points of interest justified publication. A white, 40-year-old male was afflicted with pain, tingling, and numbness along the course of the left ulnar nerve. In addition, shoulder pain that radiated upward also was present. Examination disclosed a small tumor in the inferior triangular

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space of the left side of the neck. The left pupil was contracted and the levator palpebrae did not function. The tumor grew rapidly and the patient subsequently died. A hard "scirrhus" in the left side of the neck uncovered at postmortem examination was considered to be a carcinoma. Symptoms were thought to be due to an infiltration of the brachial plexus.

Although Hare described the symptoms of ablation of the cervical sympathetic chain and noticed its involvement, he did not recognize that loss of sympathetic activity was the cause of the eye signs. Nevertheless, his case report well antedates the descriptions of Horner and Pancoast. Fairness indicates that he should at least be remembered and mentioned when these syndromes are discussed.

JOSEPH M. MILLER, M.D.
Timonium, Maryland

References

1. Gershen B. Faceless names. *Md Med J* 1994;43:71-3.
2. Pancoast HK. Importance of careful roentgen-ray investigations of apical chest tumors. *JAMA* 1924;83:1407-11.
3. Pancoast HK. Superior sulcus tumor; tumor characterized by pain, Horner's syndrome, destruction of bone and atrophy of hand muscles. *JAMA* 1932;99:1391-96.
4. Horner F, Ueber eine Form von Ptosis. *Klin Monatsbl Augenheilkd* 1869; 7:193-8.
5. Schmidt JE. *Medical Discoveries. Who and When*. Springfield, Illinois: Charles C. Thomas. 1959. pp. 219-220.
6. Hare ES. Tumor involving certain nerves. *London Medical Gazette* 1838;23:16-18. ■



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Nancy E. Gary, M.D. Dean, F. Edward Hébert School of Medicine Uniformed Services University of Health Sciences

Victor R. Hrehorovich, M.D., and Ruth M. Seaby, M.A.S.

Dr. Hrehorovich is editor of the Maryland Medical Journal and Ms. Seaby is director of communications, Med Chi, Baltimore, Maryland.

Last year, when Nancy E. Gary, M.D., became dean of the F. Edward Hébert School of Medicine at the Uniformed Services University of Health Sciences (USUHS-SOM) in Bethesda, Maryland, one of her first assessments was, "This is an excellent and exceptional medical school with a strong student body, very fine faculty, and staff dedicated to the institution." According to Dr. Gary, it is the dedication of the faculty, students, and staff, as well as the school's specialized curriculum, that make USUHS a unique and vital part of the nation's medical education system.

A uniformed services career in medicine

Created by Congress in 1972, USUHS has the specific mission to educate men and women for public service careers as medical officers in the United States Army, Navy, Air Force, and Public Health Service. The school also provides specialized medical support training for law enforcement, fire, and rescue personnel. In addition, the school offers fully accredited graduate programs in the basic medical sciences.

"The school is unique because its students are committed to serve the nation," notes Dr. Gary. "Their dedication to serve the good people of this country strengthens while they are here." For many USUHS-SOM graduates this commitment extends beyond their obligatory service period; 89% of the school's armed forces graduates who have completed this service period remain in the military. "Here is an example of an arrangement at a school that educates competent physicians and develops their commitment to stay in the nation's service beyond their payback period," states Dr. Gary.

Applicants to USUHS-SOM are required to have the same basic course work, GPA, and MCAT scores as applicants to any other medical school. "We also look very hard for indicators that applicants are committed to public service," says Dr. Gary. "Students who come through the military route, either from ROTC, military academies, or active duty, know the military environment and have decided that this is what they want to do. If applicants don't have this type of experience, we look for a record of community service

Uniformed Services University is composed of two schools: The F. Edward Hébert School of Medicine (USUHS-SOM) and the Graduate School of Nursing.

or other things that characterize someone who is likely to pursue a career in public service.”

Since the majority of USUHS-SOM students fulfill a commitment to serve in the military after graduation, their education must include specialized medical and military training. As Dr. Gary points out, “They are physicians taking care of a community—an air squadron or wing, a brigade or division of troops, or an entire complement of officers and enlisted personnel at sea. They need to be prepared to support American troops in unusual environments, such as Saudi Arabia or Somalia. Their education must have a greater focus on caring for people in extreme environments, preventive medicine, field sanitation, tropical diseases, infectious diseases, and parasitology than the education in a civilian medical school. The United States Public Health Service students, upon graduation, will serve in the Indian Health Service, National Health Service Corps, or Food and Drug Administration. They, along with their fellow military students, receive training in mobilizing medical services and dealing with natural and manmade disasters. This is a different kind of training than most medical schools have.” Specialized disaster training enabled USUHS treatment and research teams to assist victims and rescue workers after Hurricane Andrew in Florida, the Midwest floods, the U.S.S. Iowa explosion, and the Sioux City United Airlines crash.

Since most military medical units and organizations are commanded by military officers, training in leadership and management skills, the supervision of health care professionals, and military medical field maneuvers are integral parts of the school’s curriculum. To allow time for the additional

training, USUHS-SOM students have a longer academic year. “The average medical school curriculum takes about 155 weeks; our students go about 173 weeks over four years,” explains Dr. Gary.

On becoming dean

Dr. Gary feels her decision to become a dean was a natural evolution in her career. “I had always been in academic medicine,” says Dr. Gary, whose career has included appointments with the Health Care Financing Administration, Albany Medical College, and the New Jersey-Robert Wood Johnson Medical School. “At a point in my career, I began to look for other challenges and realized that I knew very little about the management and operation of a medical school.” While on the faculty of the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, she became involved in various administrative aspects of the institution. Ultimately, she was asked to serve as associate dean for educational affairs. “That was my transition into medical school administration. I thoroughly enjoyed it and developed ideas for different programs that would advance the school. I decided I liked the administration realm and was pleased with the opportunity to become dean, first at Albany Medical College and now at USUHS-SOM.”

Dr. Gary sees a dual responsibility in her role of dean. “Traditionally, the dean has been defined as the leader of the faculty. That is a major responsibility. Equally important is fulfilling the school’s educational mission by providing an appropriate and contemporary program for the students that prepares them for their professional responsibilities,” explains Dr. Gary.

One of her first major duties as dean at USUHS-SOM was to oversee the reaccreditation processes of the Liaison Committee on Medical Education, the accrediting body for all U.S. medical schools, and the Commission on Higher Education of the Middle States Association. “I am pleased that both of those went exceptionally well, due to the commitment of the faculty and students. We were reaccredited to the maximum level by both organizations,” says Dr. Gary.

Curriculum

With the reaccreditation process successfully completed, Dr. Gary turned her attention to the school’s curriculum. “I want to help the school shape its program so that it’s not just another traditional curriculum for medical education, but instead is linked and tailored to the professional activities in which our graduates will practice in the next twenty years.” She has requested that faculty form a committee to review and revise the curriculum so



USUHS curriculum includes military medical field studies which provide students with field training and leadership exercises.



Dr. Gary stands next to a statue of F. Edward Hébert, the Congressional representative who, in 1972, sponsored the Uniformed Services Health Professions Revitalization Act that authorized the establishment of USUHS.

that it remains contemporary and relevant to the school's goals of academic excellence, scientific rigor, humanism, and military medical professionalism.

USUHS-SOM students receive part of their clinical training at the university's four main affiliated teaching hospitals: Walter Reed Army Medical Center in Washington, D.C.; the National Naval Medical Center in Bethesda, Maryland; Malcolm Grow USAF Medical Center at Andrews Air Force Base, Maryland; and Wilford Hall USAF Medical Center in San Antonio, Texas. To provide students with a consistent program at these sites, the clinical faculty members located at the school routinely meet with student program directors at the other facilities. "This school has a wonderful faculty that is cohesive, works together, and is scientifically first rate," states Dr. Gary.

One change to the school's curriculum that Dr. Gary envisions is integrating women's health issues into the entire four-year program. More women are entering the military and Dr. Gary sees an increasing need to address issues such as prevention of osteoporosis and coronary artery disease in women. "We also need to learn more about the psychological effects that participating in combat and being a prisoner of war have on women so that we can better educate the health professionals who will care for these women. Women's health issues should not be defined only as those disorders typically cared for by an obstetrician/gynecologist," says Dr. Gary.

To complement its medical program, the school recently expanded its graduate instruction to include interdisciplinary doctoral programs in neuroscience and molecular and cell biology. The university also has begun a graduate school of nursing and soon will start a program for nurse anesthetists. These programs are available to the uniformed services.

Research

Dr. Gary also wants to help the school enhance its already outstanding research program. The school currently conducts research in areas that are important to the Department of Defense, such as wound healing and infectious diseases. One notable effort in pediatric infectious diseases research has led to the development of a respiratory syncytial virus immune globulin. The school is also doing a significant amount of cancer research, particularly in tumor biology and prostatic cancer.

The military as a model for managed care

As a result of national health system reform, the majority of citizens eventually may receive medical care in a managed care environment. Dr. Gary thinks the military medical treatment system and USUHS-SOM are uniquely positioned to help develop the new health care system because of the military's extensive experience in managed care. "The military has always delivered health care under a global budget. Quality assurance and cost-effectiveness are already integral parts of the operation at military treatment facilities. Any managed



89% of USUHS-SOM graduates remain in the military after fulfilling their obligatory service period.

care facility in a civilian sector will have to deal with the budget, maintain quality, and operate efficiently. I think a great deal can be learned from the military treatment facility model," says Dr. Gary.

She also thinks the school could be a resource for demonstration projects or other research efforts that help resolve some of the issues associated with health system reform. "The school could develop objective quality-of-care information through a research project or contract that formulates the proper questions, then finds, gathers, and develops the relevant data."

USUHS future

In September 1993, Vice President Gore issued "The Vice President's National Performance Review Report." One of the report's recommendations was that USUHS be closed. This recommendation is based on the belief that military physicians can be trained more economically through other means, such as the Health Professions Scholarship program. USUHS supporters contend, however, that the school provides specialized training for the military that is not available elsewhere. Since September, the House of Representatives passed legislation that expressly allows one more incoming class, with closure planned in 1998. The Senate has not acted on this legislation.

One of the greatest challenges Dr. Gary currently faces as dean is guiding the school through this difficult period. She hopes that forthright communication will help maintain the morale of the faculty, students, and staff. "I think the important thing to do is keep everyone well informed. Meet with the USUHS community, encourage them to continue doing their tasks and to be exemplary employees or outstanding students," says Dr. Gary. "I hope that one of the things I'll be remembered for is the leadership that I've provided to the faculty and students as the school goes through this period." ■

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Secondary epiretinal membrane after blunt trauma

Joseph K. W. Hsu, M.D., Julia A. Haller, M.D., Zenaida de la Cruz, B.S., and W. Richard Green, M.D.

Dr. Hsu is a research fellow at the Wilmer Eye Institute; Dr. Haller is assistant professor of ophthalmology at The Johns Hopkins University School of Medicine; Ms. de la Cruz is an electron microscopist at the eye pathology laboratory at The Johns Hopkins Hospital; and Dr. Green is professor of ophthalmology and pathology at The Johns Hopkins University School of Medicine, Baltimore, Maryland.

ABSTRACT: *Electron microscopic study of a surgically removed epiretinal membrane secondary to blunt trauma disclosed the membrane to be hypocellular and lined by internal limiting membrane on the external surface and by a layer of fibrocytes and myofibrocytes on the internal surface. The membrane was composed predominantly of new collagen. Occasional fibrous astrocytes, rare macrophages, and no blood vessels were present.*

Epiretinal membranes (ERMs) may occur after retinal breaks, ocular surgery, intraocular hemorrhage and inflammation, developmental abnormalities, ocular trauma, or in otherwise normal eyes.¹ The three principal cells involved in the formation of ERMs are fibrous astrocytes, retinal pigment epithelial cells, and fibrocytes.² Fibrous astrocytes gain access to the inner surface of the retina through naturally occurring and acquired defects in the internal limiting membrane (ILM), proliferate, contract, and produce collagen, which perpetuates the contracted state.² Natural defects of the ILM occur at the foveola and optic nerve head, over major retinal vessels, and at retinal tufts. Acquired defects occur with retinal pits, tears, and holes; avulsed retinal vessels; areas of lattice degeneration; and at random sites of vitreous traction. Previous authors observed an association of posterior vitreous detachment (PVD) with idiopathic ERMs.^{3,4} The presence of native collagen in ERMs suggests that a thin layer of cortical vitreous may remain along the ILM despite apparent PVD.⁵

We present the clinical and histopathologic features of an ERM following blunt trauma in a lacrosse player.

Case report

A 36-year-old white female presented with unilateral, blurred and distorted vision in the left eye. She gave a history of blunt trauma from a lacrosse ball to the left eye 15 years earlier. Two years prior to her presentation, she had a normal ophthalmoscopic examination.

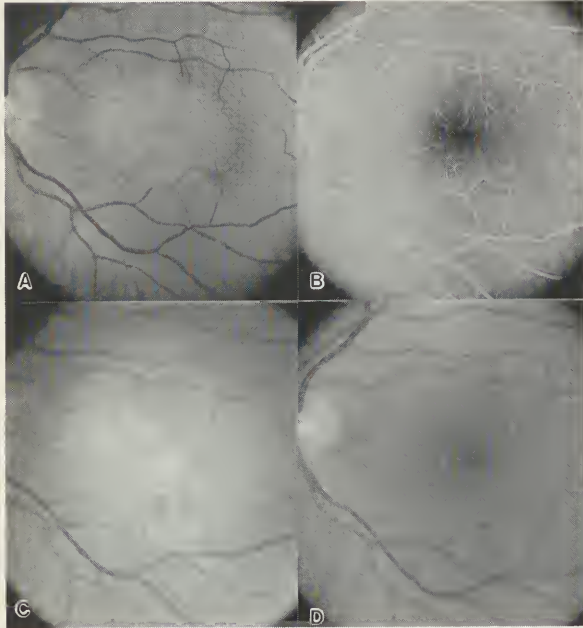


Figure 1. Red-free fundus photograph of the left eye (A) reveals a thin, cellophane-like, nonvascularized ERM over the left macula with mild radial striae of the ILM. Fluorescein angiography (B) reveals mild contracture of the ILM in the macular area with gathering of the vessels toward the fovea. Preoperative appearance (C) shows progression of the membrane. Ophthalmoscopic appearance one year after surgery (D) reveals no recurrence of the epiretinal membrane.

At presentation, visual acuity in the right eye (OD) was 20/16 (within normal limits); in the left eye (OS) it was 20/25. Examination of the left eye revealed a clear cornea, full visual fields, and some central distortion on the Amsler grid. Anterior chamber angle recession was present for three clock hours superiorly. Ophthalmologic examination revealed a thin translucent membrane over the macula with moderate distortion and pulling together of the retinal vessels (**Figures 1A and 1B**). The vitreous was detached, but remained attached to the area of the membrane.

Over a two-year period, progressive worsening of the membrane occurred, with wrinkling, macular traction striae, and reduction of visual acuity to 20/50 (**Figure 1C**). The patient underwent pars plana vitrectomy and removal of the membrane. Visual acuity improved from 20/50 to 20/20 with no recurrence of the ERM after one year (**Fig. 1D**).

Materials and methods

The ERM was removed using intraocular forceps and placed in a buffered 1% glutaraldehyde and 3% formaldehyde solution for electron microscopy as previously described.⁶ The remainder of the vitreous aspirate was concentrated with a millipore filter and stained with a modified Papanicolaou technique for light microscopy.⁷

Results

Examination of the concentrated vitreous aspirate revealed occasional ILM (**Figure 2A**) and fibrocellular membrane

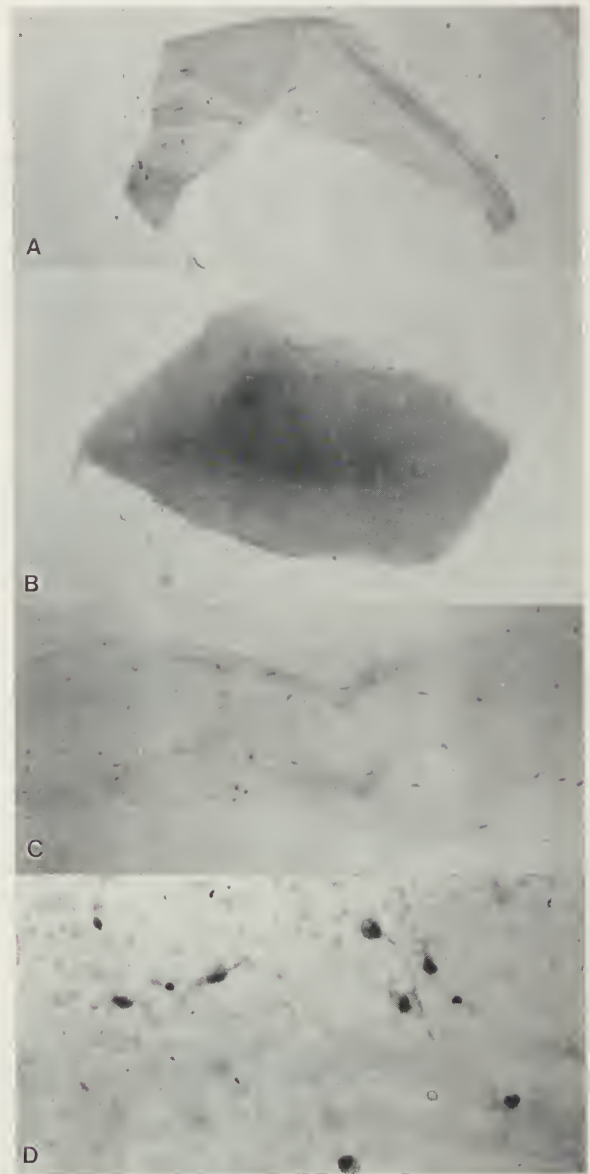


Figure 2. Surgical specimen obtained at the time of pars plana vitrectomy contained fragments of ILM (A), fibrocellular membrane fragments (B), vitreous strands with spindle- and stellate-shaped cells and a light scattering of lymphocytes (C and D). (Millipore filter preparation, modified Papanicolaou stain: A, B, and C, x340; D, x544).

fragments (**Figure 2B**). Numerous vitreous strands, some with spindle- and stellate-shaped cells (**Figure 2C**), and a light scattering of lymphocytes (**Figure 2D**) were present.

Examination of 1-micron thick, plastic-embedded sections disclosed a thin fibrocellular membrane measuring 3.2 mm (maximal diameter) and 0.07 mm (maximal thickness). ILM lined the external surface of the membrane and occasional spindle-shaped cells were present on the internal surface. Rare round cells were present within the membrane.

Transmission electron microscopy (TEM) revealed a hypocellular membrane with a collagenous matrix composed of collagen of three different sizes, ILM lining the external

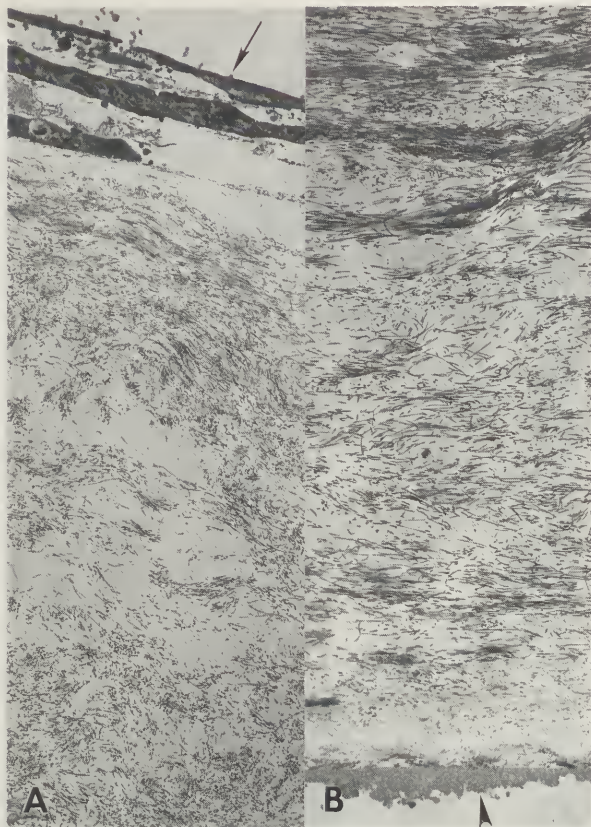


Figure 3. Ultrastructural appearance of near full-thickness of nonvascularized hypocellular ERM in two segments lined by a layer of fibrocytes and myofibrocytes (arrow) on the inner surface (A) and ILM (arrowhead) on the outer surface (B). The bulk of the collagen has a fiber diameter measuring 25 nm with a scattering of 15 nm fibers. (A and B, x6,000).

surface, and a layer of fibrocytes and myofibrocytes lining the internal surface (**Figure 3**). The collagen matrix was predominantly composed of collagen with a fiber diameter of 25 nm intermingled with a scattering of collagen with a fiber diameter of 15 nm. A thin band of collagen lying just internal to ILM had a fiber diameter of 33 nm (**Figure 4**). Occasional fibrous astrocytes (**Figure 5**) and rare macrophages (**Figure 6**) were present within the membrane. No blood vessels were present.

Discussion

Macular ERMs may occur after accidental and surgical trauma.^{8,9,10} We present a case of an ERM that developed 15 years after blunt trauma. For 12 years after the trauma, the patient had a visual acuity of 20/20 without complaints of visual distortion. Ophthalmoscopic examinations did not show any clinically appreciable ERM during that interval and there was no subsequent ocular trauma or inflammation. It is possible that an ERM was present, was visually insignificant and stable, and became visually significant after an unknown stimulus instigated the resumption of cellular activity. Another possibility is that the translucent ERM became apparent and symptomatic only after most of the cortical vitreous separated from the retinal surface, exerting traction on the remaining attachment

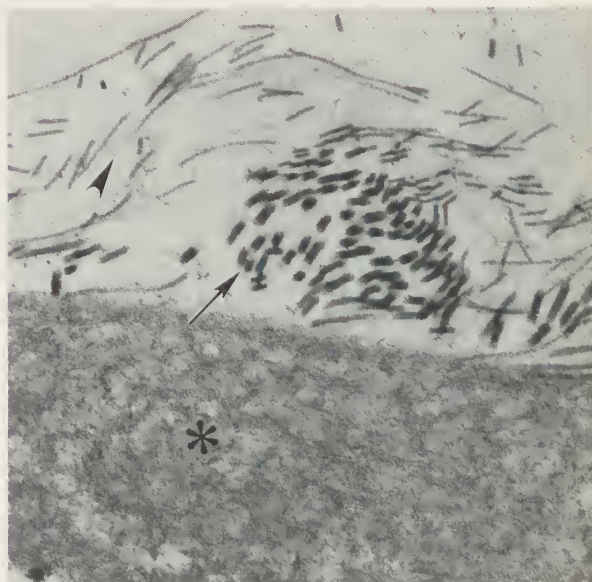


Figure 4. Higher power (x60,000) view of collagen with fibers measuring 33 nm (arrow) and 15 nm (arrowhead) in diameter on the inner surface of the ILM (asterisk).

at the macula. A partial PVD was observed, but vitreous remained attached to the area of the membrane as observed intra-operatively. The ERM partially obscured the underlying retinal blood vessels. Fibrocytes, fibrous astrocytes, retinal pigmented epithelial (RPE) cells, macrophages, and myofibroblastic cells have been observed in ultrastructural studies of ERMs.^{6,11-16} The membrane in this case was composed of new collagen and some native collagen (16 nm in diameter)¹⁷ with fibrocytes, occasional fibrous astrocytes, myofibrocytes, and macrophages. The finding of native collagen further suggests that cortical vitreous was present at the anterior aspect of the ERM. No RPE cells were present. Five ERMs reported by Kampik et al⁶ and one ERM reported by

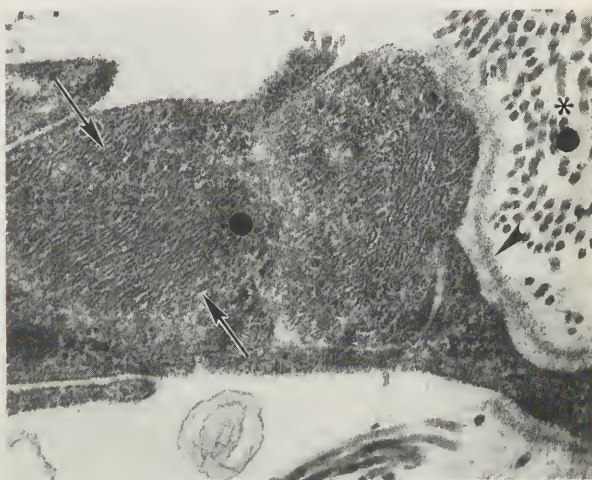


Figure 5. Fibrous astrocyte with basement membrane (arrowhead) and bundles of cytoplasmic filaments measuring 10 nm in diameter (between arrows) (asterisk - 33 nm collagen) (x60,000).

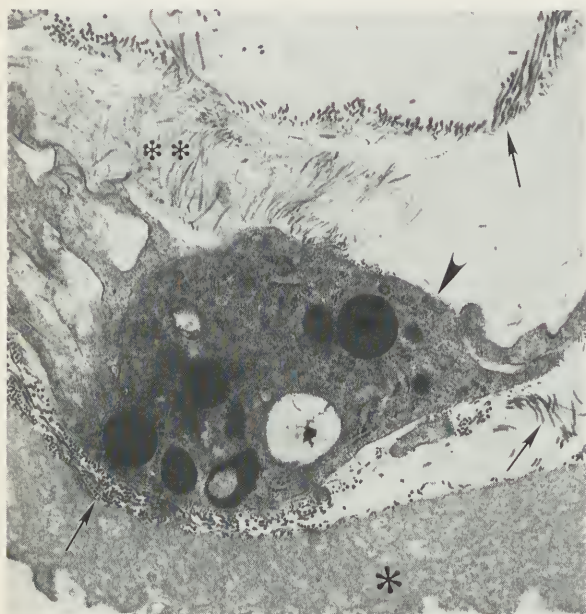


Figure 6. Area with a macrophage (arrowhead) with multiple membrane bound inclusions, ILM (single asterisk), and 33 nm (large arrows) and 15 nm (small arrow) collagen (2 asterisks) (x20,100).

Maguire et al¹⁸ that were secondary to trauma also did not have RPE cells and were similar to the current case.

The pathogenesis of the ERM in this case is unknown. Fibrous astrocytes are thought to migrate onto the surface of the ILM through defects in the ILM. No apparent defects were observed clinically in the ILM in this patient. A focal defect of the ILM at the foveola, however, may be a site where glial cells gain access to the inner surface of the retina. PVD also has been postulated as a stimulus for glial proliferation by causing tangential traction on the macula. The blunt trauma in our case may have led to a partial posterior vitreous detachment except at the macula, thus stimulating fibrous astrocytes to migrate and proliferate through a foveolar defect in the ILM.

A light scattering of lymphocytes was present in the vitrectomy specimen of this case. Perhaps the lymphocytes and their interaction with various molecular compounds (e.g., fibronectin, platelet derived growth factor, and transforming growth factor-beta) may act as a stimulus for cellular proliferation and ERM formation. Trauma is known to cause a breakdown in the blood ocular barrier and may have triggered a cascade of events culminating in a visually symptomatic ERM after many years. The precise cause of ERM formation after blunt trauma remains unknown.

References

1. Michels RG. A clinical and histopathologic study of epiretinal membranes affecting the macula and removal by vitreous surgery. *Trans Am Ophthalmol Soc* 1982;80:580-656.
2. Green WR. Periretinal proliferation. In: Franklin RM (ed). *Proceedings of the 1992 Symposium on Retina and Vitreous, New Orleans Academy of Ophthalmology, New Orleans, Louisiana*. New York: Kugler Publications. 1993. pp. 98-128.

3. Kampik A, Green WR, Michels RG, Nase PK. Ultrastructural features of progressive idiopathic epiretinal membrane removed by vitreous surgery. *Am J Ophthalmol* 1980;90:797-809.
4. Foos RY. Vitreoretinal juncture in epiretinal membranes and vitreous. *Invest Ophthalmol Vis Sci* 1977;16:416-22.
5. Clarkson JG, Green WR, Massof D. A histopathologic review of 168 cases of preretinal membrane. *Am J Ophthalmol* 1977;84:1-17.
6. Kampik A, Kenyon KR, Michels RG, Green WR, de la Cruz ZC. Epiretinal and vitreous membranes: Comparative study of 56 cases. *Arch Ophthalmol* 1981;99:1445-54.
7. Gill GW, Millio KA. *Laboratory Cytopathology Techniques for Specimen Preparation*. Baltimore: The Johns Hopkins University School of Medicine. 1973. pp. 1-31.
8. Kampik A, Green WR, Michels RG, Rice TA. Epiretinal Membrane nach Photokoagulation (post-koagulative Maculopathie). *Berichte Deutsche Ophthalmologische Gesellschaft* 1981;78:593-8.
9. Lang GK, Green WR, Maumenee AE. Clinicopathologic studies of keratoplasty eyes obtained postmortem. *Am J Ophthalmol* 1986;101:28-40.
10. Wilson DJ, Green WR. Histopathologic study of the effect of retinal detachment surgery on 49 eyes obtained postmortem. *Am J Ophthalmol* 1987;103:167-79.
11. Smiddy WE, Maguire AM, Green WR, Michels RG, de la Cruz Z, Enger C, Jaeger M, Rice TA. Idiopathic epiretinal membranes. Ultrastructural characteristics and clinicopathologic correlation. *Ophthalmology* 1989;96:811-20.
12. Green WR, Kenyon KR, Michels RG, Gilbert HD, de la Cruz Z. Ultrastructure of epiretinal membranes causing macular pucker after retinal reattachment surgery. *Transactions of the Ophthalmological Societies of the United Kingdom* 1979;99:65-77.
13. Machemcr R, Laqua H. Pigment epithelium proliferation in retinal detachment: Massive periretinal proliferation. *Am J Ophthalmol* 1975;80:1-23.
14. Smiddy WE, Michels RG, Gilbert HD, Green WR. Clinicopathologic study of idiopathic macular pucker in children and young adults. *Retina* 1992;12:232-6.
15. Laqua H, Machemer R. Glial cell proliferation in retinal detachment: Massive periretinal proliferation. *Am J Ophthalmol* 1975;80:602-18.
16. Laqua H, Machemer R. Clinical-pathological correlation in massive periretinal proliferation. *Am J Ophthalmol* 1975;80:913-29.
17. Hogan MJ, Alvarado JA, Weddell JE. *Histology of the Human Eye*. Philadelphia: WB Saunders. 1971. pp. 607-8.
18. Maguire AM, Smiddy WE, Nanda SK, Michels RG, de la Cruz Z, Green WR. Clinicopathologic correlation of recurrent epiretinal membranes after previous surgical removal. *Retina* 1990;10:213-22. ■

Telephone communication when the patient is deaf or hard-of-hearing

Willis J. Mann

Mr. Mann is director of the telecommunications access program (TAM) in the Maryland Department of General Services, Baltimore. TAM oversees provision of the Maryland relay for the state of Maryland.

ABSTRACT: *Newly developed technology and specially trained operators offer physicians and deaf or hard-of-hearing patients several options for communicating by telephone. This article discusses communication equipment, implications and benefits of direct physician/patient communication, removal of communication barriers, and confidentiality.*

Many physicians have patients who are deaf or hard-of-hearing. Despite the obvious communication problems this disability may present, even in face-to-face encounters, physicians today can communicate by telephone with these patients in one of two ways. The first method is for both physician and patient to have what are called telecommunications devices for the deaf (TDDs) or text telephones (TTs). These are electronic devices somewhat like a small typewriter that may or may not be equipped with a printer. To place a call, one party simply puts the telephone handset on the top of the machine and dials the other party's number. When the second party answers, the two people communicate back and forth by typing. In order to communicate this way, however, each party must have a TDD.

The second method is the Maryland Relay Service (MRS), which has been in operation for over two years. It is the fourth busiest relay in the nation, but ranks first in the country in per capita usage. A relay system serves as a link between a hearing person without a TDD and a deaf or hard-of-hearing person who has a TDD. To call a deaf or hard-of-hearing patient through MRS, the physician first places a call to the MRS center in Baltimore using the telephone method normally used (voice or TDD). At MRS, a specially trained operator with access to both a voice and TDD line places the call to the patient, listens to the physician's spoken words, and types them to the patient. The patient responds either by typing or voice.

Deaf or hard-of-hearing patients who cannot speak clearly enough to be understood can simply type their portion of the conversation, which the relay operator reads to the physician. For those who can speak well, such as late-deafened or hard-of-hearing adults, a special system called voice carryover

(VCO) is available. In a VCO call, everything the physician says is typed verbatim to the patient's TDD. The patient can then respond by voice directly to the physician, with the relay operator continuing to convey the physician's spoken words via typing to the patient's TDD. VCO calls are very much like regular voice calls except for the slight lag time during which the physician's portion of the conversation is being typed.

For those who have normal hearing but have lost or never had the ability to speak, a system called hearing carryover (HCO) is also available. HCO works in reverse of VCO. The patient listens to the physician's words and then types a response that the operator voices to the physician.

The implications of using a relay system to communicate with deaf or hard-of-hearing patients are important. MRS allows the physician to communicate directly with the patient instead of having to go through a third party such as a family member or friend, who may have a vested interest in the welfare of the patient. MRS thus avoids the commonly occurring situation in which wrong information is given or critical information is withheld from a patient who has little or no control over conversations between the physician and the third party. It also prevents situations from arising in which the third party makes judgmental decisions based on what he or she presumes to know or feels would be in the best interests of the patient.

MRS also allows physicians to make better use of their time. When third parties are involved, they must stop the conversation from time to time to explain to the patient what is said, thereby making the call a long, drawn-out process fraught with difficulty and the possibility of misunderstandings. In addition, MRS allows physicians to call deaf/hard-of-hearing patients at any time during business hours, or even after hours, just as they would any other patient.

There are several benefits to patients as well in using MRS to communicate with their physician(s). First is the sense of privacy. Using MRS, patients no longer have to convey highly confidential, possibly embarrassing or distressing personal information through a family member or friend. Second, they are able to get exact, detailed answers from the physician, often in printed form from their TDD, which helps them remember what has been explained. Third, they retain a sense of control over and participation in decisions concerning their medical situation. Finally, they also can make calls as the need arises and do not have to rely on the generosity or availability of another person.

An obvious question arises concerning the confidentiality of relay communications. MRS and other relay systems are covered by Article IV of the Americans with Disabilities Act, which, among other things, calls for total confidentiality of information relayed. When a call is completed, all information on the relay operator's computerized TDD screen disappears and cannot be retrieved or recorded. In addition, at no time do relay operators interject their thoughts, opinions, or feelings into the conversation. Remarks should not be addressed to them and their opinion should not be sought. They are there to facilitate communication and nothing else. Operator "transparency" is the ultimate goal so that all communication is strictly between the physician and patient.

To obtain additional information or descriptive literature on the Maryland Relay Service, call the Telecommunications Access of Maryland program (410-225-6960 in the Baltimore calling area or 1-800-552-7724 within Maryland). ■

Med Chi Bicentennial Celebrations

Med Chi has already begun planning celebration activities for its bicentennial in 1999. If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at 410-539-0872 or 1-800-492-1056.

Hospice: The most important thing you didn't learn in medical school

F. Michael Gloth, III, M.D.

Dr. Gloth is chief of geriatrics at The Union Memorial Hospital in Baltimore, assistant professor of medicine at the Johns Hopkins University School of Medicine, and medical director at Carroll Hospice in Westminster, Maryland.

ABSTRACT: *Much of medical education is devoted to curing disease. Surprisingly little formal attention is given to the dying process and how physicians can best care for dying patients and their families. Nevertheless, the hospice concept is growing and the growth shows no sign of slowing down. The number of hospices in the United States has increased from 440 in 1981 to about 2,000 in 1994. Access to hospice in Maryland is limited primarily by ignorance, on the part of both health care professionals and the public, about its availability and purpose. This article provides a history of the hospice concept and information about the current status of hospice in the State of Maryland.*

One of the major challenges in the practice of medicine today is providing optimal care, including comfort and relief, for the dying patient. In this era of cost consciousness about health care and media attention to assisted suicide, the hospice concept seems inexplicably forgotten.

The history of hospice

The concept of hospice was evident even in medieval times. The hospice station was a place for the weary, the sick, and the poor. During the days of the Crusades, travelers commonly sought shelter from a long journey in such a place of rest. During the nineteenth century, the Irish Sisters of Charity created a string of hospices in Great Britain, starting with St. Joseph's in London. These hospices were designed to provide comfort for the weary, the sick, and the dying.

The modern medical hospice model was created by Cicely Saunders, M.D., who, as a social worker, was inspired by a young man whom she helped through the dying process. She then decided to devote her life to formal medical care oriented toward the dying patient. Entering the field of nursing after her social work experience, Cicely Saunders later became

a British physician. In 1967, she began the first modern inpatient hospice, St. Christopher's, which is still in existence. Its opening was a landmark advance for hospice philosophy in medical practice. Dr. Saunders' efforts did not go unnoticed in England; she was awarded the title *Dame* by the British monarchy.

In the United States, a book by Elisabeth Kübler-Ross, M.D., *On Death and Dying*, brought care of the dying patient to the attention of the medical community and society in general in 1969. The first hospice in the United States was founded in Connecticut in 1974. Medicare began offering a hospice option in 1983 and today almost 1,000 hospices are Medicare-certified.

Hospice is one of the fastest growing segments of our health care system. According to the Hospice Council of Metropolitan Washington, hospice use has increased by about 16% in recent years. The Hospice Network of Maryland reports increases of about 10%. The Academy of Hospice Physicians lists over 1,300 members in 35 specialties. According to figures from the National Hospice Organization, about 2,000 hospice programs nationwide serve almost 250,000 terminally ill patients and their families per year. The Hospice Network of Maryland currently lists 38 operational hospices in Maryland with at least one hospice organization in every county in the state. Maryland hospices currently serve about 4,500 patients and their families.

Understanding hospice

Hospice care is directed toward the dying patient for whom we have no curative therapy. The hospice philosophy focuses on decreasing suffering and increasing comfort and dignity in the terminal stages of life. Physical, emotional, social, and spiritual comforts are all incorporated into hospice care. Patients in hospice are allowed to die with dignity and often in the comfort of their own homes. In 1992, a Gallup poll indicated that 90% of Americans prefer to receive care at home in the event of a terminal illness.

Management is not designed to prolong a patient's suffering; patients undergoing intensive therapy, which is designed only to prolong life, may not be ready for hospice. This does not mean that hospice does not use state-of-the-art techniques to manage pain and provide comfort. In addition to "high-tech" therapies for providing care, such as in-home infusion therapy, there is also tremendous emphasis on the "high-touch" component of palliative care. Hospice works not only with the patient, but also with the family, with particular sensitivity to the various stages of dying (denial, anger, bargaining, depression, and acceptance). Emphasizing quality of life rather than length of life, the team approach provides skilled assistance and teaches family caregivers how to provide optimal care for their loved one. The focus does not stop with immediate medical care, but encompasses any aspect of an individual's life that will facilitate the goals of comfort and dignity for the dying patient.

An alternative to assisted suicide

The hospice philosophy does not involve or advocate euthanasia. Indeed, many would consider hospice to be the preferable solution for the terminally ill patient. Hospice care incorporates a multidisciplinary approach that allows the patient to prepare for death and to minimize suffering. Equating death with suffering has been the primary impetus behind assisted suicide. Hospice provides the alternative wherein the patient can go through the dying process without the fear of suffering.

Hospice provides a team approach that allows the patient optimal preparation for the final days of life. In addition to medical personnel—including the medical director, multiple nurses, and nursing aides—hospices make available a psychologist or bereavement counselor, spiritual assistance with accessibility to chaplains versed in multiple spiritual philosophies, and a host of other ancillary personnel including physical therapists, occupational therapists, speech therapists, nutritionists, massage therapists, and a plethora of volunteers.

A hospice organization can provide respite for the family and help with other issues such as financial or social problems. The medical, psychological, and emotional support does not end with the death of the patient; bereavement counseling and hospice support continue for the family, both short- and long-term, after a patient's death.

Who pays?

Authorized services covered by Medicare benefits are paid in full. Except for a 5% co-payment on drugs and authorized respite care, there is no charge to the patient or family. Services and care unrelated to the terminal illness, however, are not covered, although standard Medicare coverage and Medicare Part B may pay for many of such costs. Only Medicare-certified hospices can provide care that qualifies for the Medicare hospice benefit. Such hospices also file all the Medicare hospice benefit claims, thus avoiding confusing and time-consuming paperwork for the patient and family at a time when relief from such burdens is most welcome.

The Medicare hospice benefit is only available to recipients of Medicare Part A. In such circumstances the patient's physician and the medical director of the hospice must certify that the individual has a life expectancy of six months or less. The six-month timeline, however, does not mean that patients will be removed from hospice should they survive longer. Data indicate that it is very difficult to predict lifespan in hospice patients.¹ In reality, most hospices receive referrals at a very late stage when there is inadequate time to provide all of the benefits that hospices make available to patients and their families.

In order to opt for the hospice Medicare benefit, the patient must choose hospice-provided care instead of the standard Medicare benefits and choose a hospice that is Medicare-

certified. Under the Medicare hospice benefit, most services that are needed to stay at home during a terminal illness are covered. The benefit is designed to cover many more services than the standard Medicare coverage allows, whether in-hospital or with a home health agency. Some services covered include physician services, skilled nursing, continuous care in a crisis, medication and treatments to relieve pain and illness-related symptoms, physical therapy, occupational therapy, and speech/language therapy. Medical supplies and equipment and short-term inpatient care for pain control or symptom management also are covered. Additionally, the Medicare hospice benefit includes social services, trained volunteers, pastoral counseling, help with food and diet, home health aides and homemaker services to help the primary caregiver, intervals of inpatient care to give the primary caregiver respite, and bereavement services. Patients who reside permanently in long-term care facilities also are eligible for Medicare hospice benefits as long as the nursing home agrees to work with the hospice team.

Not all terminally ill patients are elderly or Medicare-eligible. Individuals not covered by the Medicare benefit may find that third-party payers, including HMOs, often have hospice provisions and will cover this worthwhile service.

Hospice and health care costs

Almost one third of health care dollars are spent in the last year of life and almost half of the costs occur in the last two months of life.^{2,3} Cost savings through hospice care have been demonstrated repeatedly.⁴⁻⁶ Health care costs for hospice patients not receiving Medicare or Medicaid benefits also are reduced; they are about \$1,430 less than those for comparable nonhospice patients.⁷

Conclusion

Hospice is a concept that should be embraced and understood by all physicians. The use of hospice allows physicians to continue to care for their patients in a more comprehensive manner. Hospice relieves a considerable degree of burden from the physician without usurping the physician/patient relationship. By enrolling hospice early in the care of terminally ill patients, physicians can help patients and their families anticipate less suffering and anxiety as well as cost-efficient care.

With 9 out of 10 Americans desiring to die in their own home or in a family member's home when facing a terminal illness, there is clearly a need for more resources for hospice care. Hospice is of benefit not only to patients and their families, but to physicians and society as well. We can ill afford to be ignorant of this vital component of medical care.

References

1. Forster LE, Lynn J. Predicting life span for applicants to inpatient hospice. *Arch Intern Med* 1988;148:2540-43.

2. Bayer R, Callahan D, Fletcher J, Hodgson T, Jennings B, Monsees D, Sieverts S, Veatch R. The care of the terminally ill: Morality and economics. *N Engl J Med* 1983;309:1490-94.
3. Long SH, Gibbs JO, Crozier JP, Cooper DL Jr, Newman JF Jr, Larsen AM. Medical expenditures of terminal cancer patients during the last year of life. *Inquiry* 1984;21:315-27.
4. Mor V, Kidder D. Cost savings in hospice: Final results of the National Hospice Study. *Health Serv Res* 1985;20:407-22.
5. Hannan EL, O'Donnell JF. An evaluation of hospices in the New York State Hospice Demonstration Program. *Inquiry* 1984;21:338-48.
6. Spector WD, Mor V. Utilization and charges for terminal cancer patients in Rhode Island. *Inquiry* 1984;21:328-37.
7. Anon. Hospice: A model for health care reforms in the U.S. *Delaware Hospice Communicator*, Fall 1993:1.

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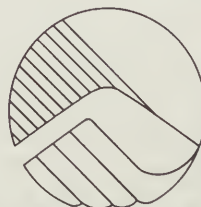
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1994 Component Society Presidents



Allegany County

AUGUSTO F. FIGUEROA, JR., M.D., became president of the Allegany County Medical Society in January 1994. Dr. Figueroa completed his premedical studies at the University of the Philippines, Quezon City, and received his medical degree from the

College of Medicine, University of the Philippines, Manila. He completed a one-year rotating internship and a residency at Philippine General Hospital. He later completed residencies in neurology and neurosurgery at New York University, Bellevue Medical Center, and West Virginia University Medical Center, Morgantown, respectively. Dr. Figueroa is the co-director of the Cumberland Valley Rehabilitation Services at Memorial Hospital and Medical Center, Cumberland, Maryland, and is a member of the medical advisory board of the Maryland Motor Vehicle Administration. He is a member of the American College of Surgeons, International College of Surgeons, Society of Philippine Surgeons in America, and American Physicians Art Association.



Baltimore City

KONSTANTINOS G. DRITSAS, M.D., was installed president of the Baltimore City Medical Society in December 1993. A native of Greece, Dr. Dritsas received his medical degree in 1957 from Aristotelion University of Salonica School

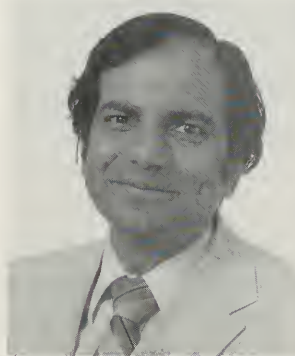
of Medicine, Greece. Dr. Dritsas moved to Madison, Wisconsin, where he served his internship and began a surgical residency at Methodist Hospital and Jackson Clinic. In 1959, he moved to Baltimore where he completed his residency training at Maryland General Hospital and did a fellowship in medical/surgical research at the University of Maryland Hospital. He then completed a second fellowship at the Surgical Medical Research Institute, University of Alberta, Edmonton, Canada. Dr. Dritsas is chief of surgery at Good Samaritan Hospital. He is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons.



Baltimore County

ALBERT L. BLUMBERG, M.D., became president of the Baltimore County Medical Association in January 1994. Dr. Blumberg received his bachelor's degree from the Pennsylvania State University and his

medical degree from Jefferson Medical College, Philadelphia, Pennsylvania. He completed his internship at the Thomas Jefferson University Hospital, Philadelphia, and a residency in radiation oncology at the University of California at San Francisco. Dr. Blumberg is a past treasurer of Med Chi. He is an active member of the medical staff of Greater Baltimore Medical Center (GBMC), vice chairman of the department of radiation oncology, chairman of the bylaws committee, and a member of the GBMC medical board. He is a fellow of the American College of Radiology, certified by the American Board of Radiology and is a member of the board, Maryland Radiological Society.



Calvert County

ANWAR ALI T. MUNSHI, M.D., assumed the office of president of the Calvert County Medical Society in January 1993. Dr. Munshi holds degrees from Jaihind College, the University of Bombay, and Grant Medical College in

Bombay, India. After completing his internship and residency at J.J. Group of Hospitals and St. George's Hospital, Grant Medical College, Dr. Munshi became house physician and registrar in internal medicine at the same institution. In 1972, he continued his training in the United States, completing an internship and residency at Mount Vernon Hospital, Mount Vernon, New York, and two additional residencies at the Hospital for Joint Diseases and Medical Center in New York. As an attending physician at Calvert Memorial Hospital, Dr. Munshi has filled the posts of chief and secretary-treasurer of the medical staff, chairperson of the department of medicine, and member of the medical executive

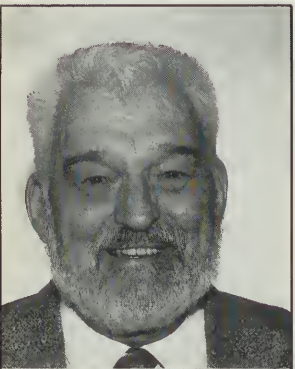
committee. He is also attending physician at Charlotte Hall Veterans Home, consulting physician at St. Mary's Hospital, and medical director at Calvert County Nursing Center and Solomons Nursing Center. Dr. Munshi is board certified by the American Board of Internal Medicine and board certified in geriatric medicine. He is a member of the American College of Physicians.



Caroline County

CHRISTIAN E. JENSEN, M.D., M.P.H., has been president of the Caroline County Medical Society since 1979. Dr. Jensen received bachelor's and master's degrees from Rutgers University. He graduated from Duke

University Medical School and earned his master's degree in public health from the Medical College of Wisconsin. He completed an internship at the Naval Hospital in Portsmouth, Virginia, and a residency in occupational medicine at the University of Cincinnati College of Medicine. He is board certified in family practice and preventive medicine in occupational medicine. A Naval Reserve captain, Dr. Jensen is a Vietnam and Desert Storm veteran. He is currently on active duty as Director of Occupational Health at Naval Clinic, Annapolis. Dr. Jensen is a member of the American Medical Association and the Delaware State Medical Society. He is a fellow of the American Academy of Family Practice and the American College of Occupational and Environmental Medicine. Dr. Jensen is author of the book *Physicians of Caroline County Maryland 1774-1984*. He farms 500 acres in Caroline County.



Carroll County

RICHARD ARVIN JONES, M.D., is the current president of the Carroll County Medical Society. He received his undergraduate degree from Bridgewater College, Bridgewater, Virginia, and his medical degree from the University

of Maryland School of Medicine, Baltimore. Dr. Jones did a rotating internship at Mercy Hospital and a medical residency in pathology at the University of Maryland School of Medicine. Dr. Jones served in the United States Air Force as chief of flight surgeons. He did a three-year residency at the United States Public Health (USPH) Hospital in Baltimore, before going to the USPH Hospital in Staten Island, New York, where he served as assistant and deputy chief of pathology. He is currently the director of the laboratory and chief of pathology at Carroll County General Hospital and is deputy medical examiner. He is a member of the American Society of Clinical Pathologists, College of American Pathology, and Maryland Society of Pathologists.



Cecil County

HENRY FARKAS, M.D., M.P.H., began his ninth term as president of the Cecil County Medical Society in January 1994. A native of New York City, Dr. Farkas attended Loyola College and Johns Hopkins University, where he received his

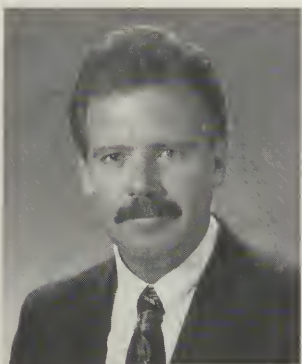
medical degree in 1970 and his master's degree in public health in 1971. After completing his internship at Lancaster General Hospital in Lancaster, Pennsylvania, Dr. Farkas served as general medical officer on a Navajo reservation in Chinle, Arizona. Returning to Maryland in 1973, he worked as an emergency physician at Harford Memorial Hospital and as medical director of the Cecil County Detention Center. Currently, Dr. Farkas practices emergency medicine at Union Hospital of Cecil County, where he has held the posts of president of the medical staff, chairperson of the emergency department, and medical director of occupational health. He also serves as medical director of the Northern Chesapeake Hospice and the Medical Adult Day Care Center of Union Hospital of Cecil County. An active member of Med Chi, Dr. Farkas serves on the peer review committee. He is a member and sits on the board of directors of the Maryland chapter of the American College of Emergency Physicians.



Charles County

WHEI-RUNG FU, M.D., is the current president of the Charles County Medical Society. Dr. Fu received his professional education at the National Taiwan University College of Medicine, Taipei. He completed an internship at Bryan Memorial Hospital,

Lincoln, Nebraska. He completed residencies in radiology at Bexar County Hospital, University of Texas Medical School, San Antonio, and University of Pennsylvania Graduate Hospital in Philadelphia, where he also did a fellowship in cardiovascular radiology. Board certified in radiology, Dr. Fu is currently attending radiologist, and chairman, department of radiology at Physicians Memorial Hospital, La Plata, Maryland. He is also clinical associate professor of radiology, Georgetown University, Georgetown University Hospital, Washington, DC.



Dorchester County

MICHAEL P. MORAN, M.D., is the current president of the Dorchester County Medical Society. Dr. Moran received his bachelor's degree from Fairleigh Dickinson University, Teaneck, New Jersey, and his medical degree from

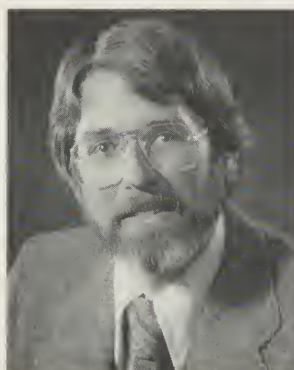
Turin Medical School, Italy. He then completed an internship, residency in internal medicine, and fellowship in gastroenterology at the Bronx-Lebanon Hospital, Bronx, New York. He was chief resident in internal medicine at Bronx-Lebanon Hospital Center. Dr. Moran is a diplomate of the American Board of Internal Medicine and the American Board of Gastroenterology. He is a gastroenterologist at Dorchester General Hospital, Cambridge, Maryland, where he also serves as a board member. He is the director of professional education, Eastern Shore division, American Cancer Society.



Frederick County

MARK D. CHILTON, M.D., became president of the Frederick County Medical Society in January 1994. He received his bachelor's degree in chemistry from Franklin and Marshall College, Lancaster, Pennsylvania, and his

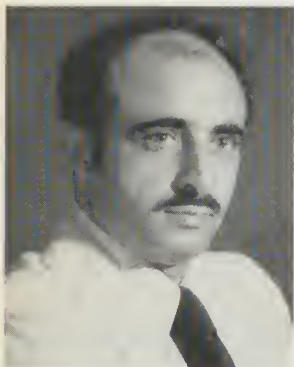
medical degree from Thomas Jefferson Medical University, Philadelphia. He completed a surgical internship and orthopedic surgery residency at the Thomas Jefferson University Hospital. Dr. Chilton has an orthopedic surgery practice in Frederick and is a member of the American Board of Orthopaedic Surgeons, American Academy of Orthopedic Surgery, Southern Orthopaedic Association, and Maryland Orthopaedic Society.



Garrett County

THOMAS G. JOHNSON, M.D., is the current president of the Garrett County Medical Society. He received his bachelor's degree from Pennsylvania State University and his medical degree from the University of Pittsburgh. He

completed a rotating internship at Roanoke Memorial Hospital. Dr. Johnson is currently chief of staff and director of the coronary intensive care unit and cardiopulmonary department, Garrett County Memorial Hospital. He is president of the Garrett Medical Group, P.A., and has a full-time family practice in Oakland, Maryland. He also is clinical assistant professor, University of Maryland department of family medicine, and assistant clinical instructor, George Washington University. Dr. Johnson is a member of the American Academy of Family Physicians and American Medical Association.



Harford County

H.A. ARFAA, M.D., was elected president of the Harford County Medical Society in November 1992. Dr. Arfaa completed his internship and then residencies in general surgery, and plastic, hand, faciomaxillary, and reconstructive

surgery in New York and New Jersey. He has served as chief of plastic, hand, faciomaxillary, and reconstructive surgery at both Harford Memorial Hospital and Franklin Square Hospital. Dr. Arfaa has served two terms as president of the medical staff, chairman of the medical executive committee, and member of the board of directors at Harford Memorial Hospital. He is a fellow of the International College of Plastic and Reconstructive Surgeons and is senior attending plastic surgeon at Maryland General Hospital.



Howard County

BRIAN J. WINTER, M.D., became president of the Howard County Medical Society in January 1994. Dr. Winter received his bachelor's and medical degrees from the University of Maryland, Baltimore. After an internship at

Maryland General Hospital, Baltimore, he spent a year in neurology and completed his ophthalmology residency at the University of Maryland Hospital. He is a member of the American Academy of Ophthalmology and Maryland Society of Eye Physicians and Surgeons. Dr. Winter is currently a staff ophthalmologist for Patuxent Medical Group, Columbia Medical Plan, Columbia, Maryland, and is a clinical assistant professor of ophthalmology, University of Maryland Hospital.



Kent County

HELEN ANDREWS NOBLE, M.D., became president of the Kent County Medical Society in January 1993. A Maryland native, Dr. Noble graduated with honors from Dartmouth College in 1978 and from the Medical College of

Wisconsin in 1987. She completed her internship and residency at Washington Hospital Center in Washington, DC. In addition to her membership in Med Chi, Dr. Noble is a member of the American College of Physicians, American Society for Internal Medicine, and American Geriatric Society. Dr. Noble is an active member and chairperson of the pharmacy and therapeutics committee at Kent and Queen Anne's Hospital. She is also medical director of the Queen Anne's Hospice and a member of the Advisory Board of the Kent County Home Health Association. She is a diplomate of the American Board of Internal Medicine and the National Board of Medical Examiners. Her honors include the Alpha Omega Alpha Honor Society, 1987, and The American Medical Women's Association Scholarship Achievement Citation, 1987. Dr. Noble currently has a private practice in general internal medicine.



Montgomery County

STEPHEN W. WHITE, M.D., will serve as Montgomery County Medical Society president April 1994 to April 1995. After receiving a bachelor's degree in American studies from Yale University, New Haven, Connecticut, Dr. White

earned his medical degree from New Jersey College of Medicine. He completed an internship and residency in pediatrics at the University of Tennessee City of Memphis Hospitals. He also did a dermatology residency at Walter Reed Army Medical Center, Washington, DC. Dr. White was a colonel in the Medical Corps, U.S. Army. He was a staff dermatologist at Walter Reed Army Medical Center during Operation Desert Storm. Dr. White is board certified in pediatrics and dermatology and is a member of the Society of Pediatric Derma-

tology, International Society of Tropical Medicine, and Society of Investigative Dermatology. Dr. White has authored 38 articles.



Prince George's County

ELIE AIME SAYAN, M.D., is the current president of the Prince George's County Medical Society. He has been a general surgeon in Prince George's County since 1966. He is a graduate of the Sorbonne Medical School, Paris, France, and

trained at the Washington Hospital Center, Washington, DC, and Prince George's General Hospital, Cheverly, Maryland. He has been an active member of the medical staffs of Prince George's, Doctors Community, and the Greater Laurel Beltsville hospitals as well as chief executive officer and chairperson of the board of directors at the old Clinton Community Hospital. He is also co-founder of Doctors Community Hospital, Lanham, Maryland. Dr. Sayan resides with his wife, Josette, in Annapolis and enjoys hunting, jogging, and music in his off hours. The proud father of nine children and seven grandchildren, he is looking forward to his son Vincent joining him in the practice of general surgery this July.



Queen Anne's County

JOHN R. SMITH, M.D., began his seventh term as president of the Queen Anne's County Medical Society in January 1994. Dr. Smith graduated from the University of Maryland School of Medicine and completed an internship and

one year of residency at Union Memorial Hospital in Baltimore, another year of residency at the Hospital for Women of Maryland, and a fellowship in internal medicine at Johns Hopkins Hospital. In 1951, Dr. Smith entered the United States Air Force; with the rank of captain, he served as chief of medicine at the Mitchell Air Force Base in Garden City, Long Island, New York. Dr. Smith maintained a private practice in New York City between 1954 and 1960, during which he was an

instructor in medicine at Cornell Medical School and an attending physician at the New York Hospital for Cornell Medical School. Since 1960, Dr. Smith has practiced internal medicine in Centreville, Maryland.



Somerset County

JAMES A. STERLING, M.D., is the current president of Somerset County Medical Society. Dr. Sterling received his bachelor's degree from Williams College, Williamstown, Massachusetts, and his medical degree

from George Washington University. He completed his internship and residency at Baltimore City Hospital and served in the United States Navy. Since 1967, Dr. Sterling has maintained a family practice in Crisfield, Maryland, the town where he was born. He is on the staff of McCready Memorial Hospital and is currently the Medical Director and Deputy Coroner for Somerset County.



Talbot County

EVA M. SMORZANIUK, M.D., is the current president of Talbot County Medical Society. Dr. Smorzaniuk received her bachelor's degree in pre-medical science from Lehigh University, Bethlehem, Pennsylvania, and her

medical degree from the Medical College of Pennsylvania, Philadelphia. She completed a family practice internship at Southside Hospital, Bayside, New York, and a radiology residency at St. Lukes-Roosevelt Hospital Center, New York, New York. Dr. Smorzaniuk also completed a fellowship in angiography and interventional radiology at Tufts-New England Medical Center Hospitals, Boston, Massachusetts. She is currently a staff radiologist at Memorial Hospital, Easton, Maryland, and is a member of the Radiologic Society of North America, American College of Radiology, Society of Cardiovascular and Interventional Radiology, and Maryland Radiologic Society.



Washington County

EDWARD W. LAMPTON, JR., M.D., has been president of the Washington County Medical Society since 1993. A native of West Virginia, Dr. Lampton graduated from West Virginia University and the University of Maryland

School of Medicine, where he was a member of the Alpha Omega Alpha Honorary Fraternity. He completed his internship at the University of Pittsburgh Children's Hospital and his residency training at the University of Maryland Hospital in diagnostic radiology. Dr. Lampton is an active member of Med Chi, serving on the legislative committee; and the American College of Radiology, serving on the government relations committee of general and pediatric radiology. He also is a member of the American Medical Association, Radiological Society of North America, American Institute of Ultrasound in Medicine, Society of Breast Imaging, and Society of Ultrasound in Medicine. He is legislative chairperson and a member of the board of the Maryland Radiological Society. Currently, Dr. Lampton, who is board certified in radiology, is a staff radiologist for Associated Radiologists, P.A., in Hagerstown.



Wicomico County

GABRIEL JOHN SOMORI, M.D., assumed office as president of the Wicomico County Medical Society on January 1, 1993. Dr. Somori holds degrees from George Washington University, Virginia Commonwealth University, and

the Medical College of Virginia. After completing his internship and residency at the Medical College of Virginia, Dr. Somori became a staff anesthesiologist at Peninsula Regional Medical Center in Salisbury. He served as chief of the anesthesiology department from 1987 to 1989, and as director of operating room scheduling from 1989 to the present. He also served as president of a nine-physician group practice from 1990 to 1992. A diplomate of the American Board of Anesthesiology, Dr. Somori holds memberships in the American Society of

Anesthesiologists and the Maryland-DC Society of Anesthesiologists, in which he serves on the legislative committee. Honors he has received include Phi Kappa Phi Academic Achievement, the H. Hertzberg Award, the Upjohn Pharmaceuticals Achievement Award, and the A.D. Williams Summer Research Fellowship. Dr. Somori was born in Budapest, Hungary, and became an American citizen in 1964.

Worcester County

STEVEN F. WATERS, M.D., began his fifth term as president of the Worcester County Medical Society in January 1994. Dr. Waters holds degrees from Catholic University with honors, and from the Georgetown University School of Medicine. After completing a family practice residency at Franklin Square Hospital in Baltimore in 1983, Dr. Waters began his private practice in family and ambulatory medicine in Ocean City. A diplomate of the National Board of Medical Examiners, Dr. Waters holds memberships in the American Medical Association, American Academy of Family Practice, and Maryland Academy of Family Practice. Dr. Waters is a native of Pennsylvania.



Resident Component

MARIA ESTELA SIMBRA, M.D., became the president of the Maryland Medical and Chirurgical Resident Society in May 1994. She received her bachelor's degree in chemistry and biology from the West Virginia University,

Morgantown, and then attended the University of Pittsburgh School of Medicine. She completed an internship in internal medicine at The Medical Center of Delaware, Christiana Hospital, Newark, and is currently doing a residency in neurology at Georgetown University Hospital in Washington, D.C. Dr. Simbra also went to the Betty Ford Center Medical Student Professional-in-Residence Summer School Program, Rancho Mirage, California, and the American Society of Pathologists' Post-Sophomore Medical Student Fellowship in Pathology, Pittsburgh, Pennsylvania. She is a member of the American Medical Association Resident Section.

Med Chi would also like to recognize component society presidents whose biographical information was not available at press time:

Anne Arundel County:

Daniel McCabe, M.D.

St. Mary's County:

Umed K. Shah, M.D.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

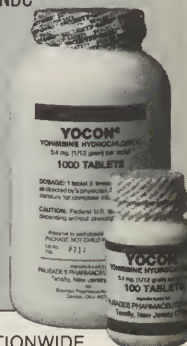
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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A Clinical Moment with Endocrinology and Metabolism

Evaluation of Unexplained Symptoms of Hypoglycemia

Dear Doctor:
A number of my patients with diabetes have complained that they feel symptoms of low blood sugar even when testing shows their sugar to be in the normal range. They want to know why they are experiencing symptoms and what is the best course of action. How can I explain and teach them to evaluate this phenomenon?

There are a number of different reasons why a person may experience symptoms associated with low sugar even though tested blood glucose is not in the hypoglycemic range. These include a rapid drop in blood sugar, chronically high, poorly controlled blood sugar, and stress and anxiety.

A rapid drop in blood sugar may fool the body into thinking that blood sugar is dropping to a dangerous level, causing the body to produce hormones that produce symptoms of hypoglycemia. Or, the brain may interpret that the blood sugar is dropping quickly and produce brain-based symptoms. In both instances, the body interprets the drop in blood sugar as dangerous, producing "warning signals" or symptoms.

A person with chronically high, poorly controlled blood sugar also can experience hypoglycemic symptoms when tested blood sugar is in the normal range. When the body becomes acclimated to chronically high blood sugar, the threshold at which symptoms are experienced rises. It is like being used to living near the equator and then moving to a northern climate where even a temperate day may feel cold. If the body is used to blood sugar levels greater than 250 mg/dL, values ranging from 80 to 120 mg/dL may be experienced as hypoglycemia.

Stress and anxiety produce a physiologic response in which adrenergic hormones are released, preparing the body to preserve blood sugar/energy for an impending (real or imagined) emergency. As a result, the person may experience a pounding heart, sweaty palms, lightheadedness,

and/or a dry mouth. The same symptoms occur during hypoglycemia, caused by the same hormones that slow or stop insulin action. Thus, patients may believe they have low blood sugar when in fact they are stressed or anxious.

To help patients evaluate the situation, instruct them to test repeatedly to make sure their blood sugar is not dropping to dangerous levels. They also should evaluate their current situation (e.g., Am I nearing a meal? Am I about to meet with the boss or have a test? Was my most recent insulin dose higher than usual? Did I forget a meal?). If their blood sugar is not dropping and they are not in danger of becoming hypoglycemic, they should take a deep breath. If they are responding emotionally to a current event, they should use their favorite calming method. If necessary, they should stop what they are doing, watch a clock, and regulate their breathing to its ticking. If no clock is available, they can match their breathing to a steady foot tap. After symptoms subside, they can resume their activity. The most important thing to stress is the importance of repeated testing.

Patients who do not feel capable of handling these episodes on their own should be referred for appropriate professional help. Make sure health professionals are familiar with diabetes and diabetes care regimens, regardless of discipline. Keep communication channels open so that information can be shared and appropriate adjustments in the patient's diabetes care regimen can be made. It is important for the patient to realize that this situation is common in the day-to-day management of diabetes and does not represent a personal failure or shortcoming.

DEBORAH YOUNG-HYMAN, Ph.D.

Dr. Young-Hyman is assistant professor of pediatric endocrinology at the University of Maryland School of Medicine, Baltimore.

JAMES H. MERSEY, M.D.

Editor ■

TO OUR READERS

A new format for "A Clinical Moment with Diabetes" has been created. Content material will now include endocrinology and metabolism, as well as diabetes. Questions will be from physician to consultant. We hope this new format will allow for more useful information for physician readers. It will also provide a forum for responding to readers' questions. If you have a particular question, please forward it to the department editor: James Mersey, M.D., Suite 411, 6565 North Charles St., Baltimore, MD 21204.

STRAIGHT Forward

INFORMATION

FOR AUTHORS

Straight Forward, a quarterly publication by the Physician Rehabilitation Committee of the Medical and Chirurgical Faculty of Maryland, informs Maryland physicians and other health care providers of developments in the areas of substance abuse, mental health, impairment, and recovery.

To accomplish this goal, the editorial consultants seek original informative or philosophical manuscripts on addiction, recovery, practice/patient management, and mental health. Calls for manuscripts on specific subjects will appear in future *Straight Forward* issues.

REQUIREMENTS FOR ARTICLES

1. Maximum length 2,500 words (about 10 double-spaced typed pages)
2. For references to other works within an article, cite the following information:
 - a. author(s),
 - b. complete title of work cited,
 - c. title of journal, publication, and publisher,
 - d. year of publication,
 - e. volume number,
 - f. first and last page number.
3. Submit two copies of the article, typed, double-spaced, with numbered pages and principal author's name on each page.
4. If possible, accompany the hard copies with an IBM-compatible WordPerfect disk (3 1/2" or 5 1/4").
5. A transmittal letter must accompany each submission and must contain the following elements:
 - a. the signature, full name, degree, title, and affiliation of the author(s);
 - b. a statement that the author(s) participated in forming the concept and drafting the article and take responsibility for its content and accuracy;
 - c. a statement granting *Straight Forward* copyright if the article is accepted for publication.

For a copy of a transmittal letter to which you can add information specific to your article, call 410-962-5580 or 1-800-992-7010.

Send submissions to *Straight Forward*
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The managing editor will acknowledge receiving your submission immediately, and will notify you of its status for publication as quickly as possible, generally within a month. Thank you for your interest in *Straight Forward*.

The editorial consultants currently seek articles on the following topics:

- substance abuse issues specific to anesthesiologists,
- stress inherent in transitions in medical practice, for example, in opening a practice, in changing specialty, in preparing for retirement.

Book Reviews

The Future of Cardiology. The Master Strategic Plan. John O. Goodman and Conrad Vernon. Las Vegas, Nevada: John Goodman & Associates, Inc. 1993. 323 pages. \$59.95

In the last 30 years there has been tremendous progress in cardiology with an explosion of diagnostic and therapeutic developments due to basic and clinical research and new technology. At the same time, the increasing number of people over age 65 and the health awareness of the population are increasing the demand for more cardiovascular care and services. The practice of cardiology, however, is being affected by many factors impacting on cardiovascular care, such as cost containment, cost effectiveness, more demand for quality of care and accountability, and reduced reimbursement. Pending health care reform with all its uncertainties and a rapidly changing health care environment create many challenges for the cardiovascular specialist.

John O. Goodman and Conrad Vernon, president and senior vice president, respectively, of John Goodman & Associates, Inc., published a timely book at this period of concerns and anxiety. It is a well-printed, easy-to-read book of 21 chapters. The authors provide a comprehensive understanding of the cardiology market, the delivery of cardiovascular care, and the needed planning considerations. They deal with the present status and the future of cardiology, addressing a strategic approach that they believe may make the difference between success and failure of a cardiology practice, hospital cardiology paradigm, or free-standing cardiovascular center.

The authors feel it is essential for cardiologists and cardiology programs to adopt an aggressive, prospective approach to comprehensive cardiovascular care. As they state: "We are in the midst of a transition that surpasses that which occurred during the Industrial Revolution. If you are to survive, not only must you recognize the existence of this transition, but you must make the changes necessary

for success in a challenging new environment.... While creation of such a plan in no way guarantees success, the lack of a long-term strategic plan insures an uncertain future at best."

The book covers the need for reviewing demographic and sociographic issues and reimbursement factors, all of which have an impact on the delivery of cardiovascular care. A mission and objectives must be set. The objectives must be realistic, attainable, and capable of winning the support of various parties. Marketing objectives should be clear. While cardiology has made tremendous technological and clinical strides in recent years, the specialty has quite a long way to go from a marketing perspective. Operational objectives dealing with day-to-day practice must be developed and met in relation to the overall strategic direction. Good management and governance of a cardiovascular delivery system are vital. If absent, they may be a significant reason for failure.

The book also addresses the capital investments needed and other financial issues. Specific financial goals must be met if the venture is to remain viable; projections of at least three years must be explored based on volumes, estimated reimbursement, and operating expenses.

In the last chapter, the authors conclude: "While change unquestionably can be unsettling, we firmly believe that the coming years will be more exciting and rewarding than any other period in the history of medicine. To come through this transition a winner will require the acceptance of new paradigms coupled with an increased focus on strategic thinking and proactive planning. If this challenge is met, you can look forward to a future of unparalleled opportunity and success."

This is a worthwhile book. The only things lacking are references and an index. Cardiologists, cardiovascular surgeons, hospital administrators, and managers of cardiology groups will find the book very useful, timely, and thought-provoking.

CHRIS PAPADOPOULOS, M.D.,
F.A.C.C.
Baltimore, Maryland



Death to Dust. What Happens to Dead Bodies? Kenneth V. Iserson. Tucson, Arizona: Galen Press. 1994. 709 pages. \$38.95

This book could be entitled the *After Death Encyclopedia*. Its 700 pages provide a wealth of information about, well, about mortal remains. The information is presented in 14 chapters, most with 200 or so references. There is also a glossary, complete index, and segment of appendices.

I am not the most qualified reviewer to comment on the technical detail, but this

book is great fun. While it answers questions about burial practices, decomposition, organ harvesting, embalming, etc., it also provides a history of thought about each topic with stories from literature, folklore, and science old and new.

Each chapter is a series of questions. For example, in Chapter 9 ("Nightmares"), Question N ("What is Necrophilia?") launches a three-page answer with straightforward explanations and clinical examples. You would not think one could find 700 pages of questions and answers, but remember that the topic is one of human fascination. Hence, the book also might be called *Everything You Always Wanted to Know About Death But Were Afraid to Ask*. Actually, it may be more than the reader wants to know, but I found most of the material interesting and quite readable. The illustrations were appropriate—mostly line drawings of historical events and practices—no gore.

The author (an Arizona surgeon who trained at the University of Maryland) makes his pitch for organ donation and more efficient recycling of dead bodies. I learned a lot from Table 13.2, which provides a list of typical funeral expenses

in the United States. Another chapter explains how to arrange for your ashes to be transported and disposed of.

Who will find the book useful? Anyone who is interested enough in the topic. It should be required reading for morticians and recommended reading for medical students. The rich background information in each chapter makes the book a valuable reference source. What it does not cover is carefully referenced.

Chapter 14 includes some catchy epitaphs. They seem to balance the detail of structural decay, a sign that wit connects us in a way that tissue cannot:

*Soon gone
Soon rotten
Soon gone
But not forgotten.*

(p. 580, Epitaph on a Massachusetts tombstone)

and

*Reader behold! and shed a tear
Think on the dust that slumbers here,
And when you read the fate of me,
Think on the glass that runs for thee.*
(p. 586, Early American epitaph)

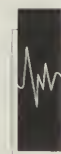
JOHN W. BUCKLEY, M.D.
Towson, Maryland ■

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Medical Information Giveaways

Popular wisdom notwithstanding, some of the best things in life are free, especially from the standpoint of medical information. This article describes some of the databases that are available to physicians free of charge. It is an impressive array. Three of the databases require a personal computer (pc), while the fourth database only requires a fax machine.

Physicians Online™

Physicians Online is a new company sponsored by the drug and health care industries that provides physicians free Windows or Macintosh search software, as well as free search time on a variety of databases. If you do not mind seeing an advertisement at the bottom of your screen while you are searching, you can obtain free access to an impressive assortment of medical databases at no cost. In addition to MEDLINE®, there is also

- ◆ AIDSLINE®: 80,000+ references to AIDS research, some of which are not included in MEDLINE®
- ◆ Physicians GenRx™: prescribing information on all FDA-approved prescription drugs
- ◆ Prescribing Decision Support Module™: drug information obtained from drug manufacturers, the FDA, and independent third-party sources
- ◆ QMR® (Quick Medical Reference): a diagnostic tool profiling more than 600 diseases
- ◆ E-mail to other users of Physicians Online™.

As a point of comparison, Grateful Med is the most widely used package for online searching of the National Library of Medicine's (NLM) databases. The software is produced by the NLM and costs \$30; the person using it is charged \$18 per hour connect time. The software developed by Physicians Online is in some ways easier to use than Grateful Med and, unlike Grateful Med, is free. According to the information provided by Physicians Online, the databases available free to physicians through their software will increase as time goes on. The only significant drawback to the software is that it does not contain an interlibrary loan module, such as the Loansome Doc function on Grateful Med. To obtain the software, call 1-800-332-0009.

CDC WONDER/PC

The Centers for Disease Control and Prevention (CDC) also provide free software and free searching (even the telephone call is free!) of public health information at CDC. CDC WONDER/PC can be used to obtain information from

Morbidity and Mortality Weekly Report (MMWR) and *CDC Online Prevention Guidelines*; obtain information about topic experts at CDC; find educational materials available through CDC; and for the researcher, plug into datasets about mortality, cancer incidence, hospital discharges, and so on. To use the software, however, you must be using an IBM-compatible pc; the Macintosh operating system is not supported.

Although CDC WONDER/PC can be used to obtain single pieces of information, such as an *MMWR* article, there are many instances in which the information sources from several parts of CDC could be used together. For example, a patient tests positive for hepatitis B. The physician can search for *MMWR* articles on hepatitis B and download the full text of such articles to his or her computer. With this background information, the physician can then use the resource index to find the names and telephone numbers of scientists at CDC who have expertise in hepatitis to discuss the current case and related morbidity and mortality associated with hepatitis B in Maryland.

Drawbacks to the CDC WONDER/PC include documentation that can be difficult to use, more problems with system availability than one encounters with the NLM databases, and for those who are Macintosh users, the absence of Mac software. If these are not insurmountable problems, however, the amount of information available is formidable.

To obtain the CDC WONDER/PC software and documentation, call 1-404-332-4569. There is a lag time of a month or more in obtaining the software, so order it well in advance of when you think you will need it.

DIRLINE

This database contains information on more than 15,000 organizations that have indicated their willingness to act as information resource centers. DIRLINE provides names, addresses, telephone numbers, and descriptions of each organization's primary interests. If you have Grateful Med, or if you search the NLM databases directly, you can access this highly useful information resource database. Currently, NLM provides access to this database free of charge.

How can it be used? Assume you receive a telephone call from a patient who has just learned that her mother has Alzheimer's disease. The daughter says she has already contacted the Alzheimer's Association, but is trying to find more sources of Alzheimer's information for herself and her

other family members. A free search on DIRLINE will turn up eight other organizations, including the Clinical Research Center at MIT (which is listed as willing to provide information on Alzheimer's research in progress) and the Institute for Basic Research in Developmental Disabilities (which will provide copies of its research reports to the public).

The strength of DIRLINE is that the organizations are indexed and also contain descriptions of their scientific interests. This means that you can find organizations willing to provide information to the public even if the organization involved does not have the particular condition as part of its name. The main drawback of the database is that the information it contains is in some instances outdated. For example, the listing for the Alzheimer's Association still provides the organization's former name. Again, however, there are no online charges for searching this database.

CancerFax

CancerFax allows rapid access to up-to-date information from the National Cancer Institute's (NCI) Physician Data Query System. The information is provided in two formats: one designed for physicians and the other designed for patients. In addition to the diagnosis/treatment information provided, CancerFax can also be used to obtain a list of

patient publications available from the Office of Cancer Communications. To access CancerFax, you need a fax machine with a telephone headset. You then call a 301 area code number and are walked through the process to obtain the information needed. When using the service for the first time, you will probably want to receive a list of the CancerFax contents first to determine which of the cancers listed will be most appropriate. In the subsequent call, you will enter the number for that description, press the start button on your fax, and then begin receiving the information.

The main strengths of CancerFax are that the information provided is detailed, specifically designed for either the physician or the patient, and up-to-date. The main drawback is that the information is at times lengthy, and thus the fax machine may be tied up for 10 to 15 minutes while the material is being transmitted. To learn more about accessing CancerFax, call 301-496-7403.

If you would like more information about any of these products, please call the Med Chi Library. We have used all of them at least on a trial basis and would be happy to help you with them.

STEPHEN M. JONES, M.A., M.S.

Mr. Jones is manager of information services for the Med Chi Library. ■

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Members in the News



ADOLFO M. ALONSO, M.D., recently was elected president of the St. Agnes Hospital Medical Staff. Dr. Alonso, who is board certified in plastic, reconstructive, and cosmetic surgery, is head of the section of plastic, reconstructive, and hand surgery at St. Agnes. He is also head of the

section of cosmetic surgery at Bon Secours Hospital in Baltimore. He received his medical degree from University of the East Medical Center in Quezon City, Philippines. He served a surgical residency at St. Agnes and a plastic surgery residency at Methodist Hospital in Brooklyn, New York. Dr. Alonso is a past president of the American Philippine Physicians of America.



JUDY M. DESTOUE, M.D., recently was named 1994 president-elect of the American Association for Women Radiologists. Currently chief of mammography for Drs. Copeland, Hyman & Shackman, P.A., Dr. Destouet received her medical degree from Baylor College of

Medicine, Texas Medical Center, Houston, Texas. Before moving to Maryland, Dr. Destouet was head of the mammography section at Mallinckrodt Institute of Radiology, Washington University School of Medicine, St. Louis, Missouri. She is a fellow of the American College of Radiology and an oral board examiner for the American Board of Radiology. Dr. Destouet is the author or co-author of more than 50 scientific articles.



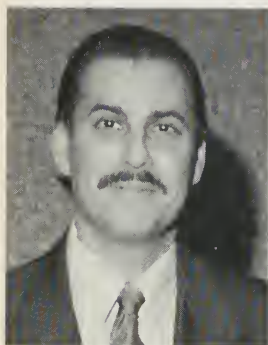
ROSEMARY HATEM BONSACK, M.D., Chairman of the Harford County Delegation, Vice Chairman of the Rules Committee, and Delegate to the Maryland General Assembly from the 34th District, recently was invited to address a conference sponsored by the University of Texas

System and the Texas Academy of Family Physicians on the primary care needs of its citizens. Dr. Bonsack shared her experience as a family physician and legislator involved in Maryland's health care package and how it is responding to the need for more family physicians. She also was recently honored by the University of Maryland Medical System for legislation she introduced that would award scholarships to medical students who agree to practice family medicine in Maryland for at least two years after completing their residency. Dr. Bonsack is a member of the Commission on Legislation and Governmental Affairs of the American Academy of Family Physicians and a past president of the Maryland Academy of Family Physicians.



MUKUND DIDOLKAR, M.D., F.A.C.S., has received a three-year appointment as cancer liaison physician for the Hospital Cancer Program at Sinai Hospital of Baltimore. The liaison program is part of the Commission on Cancer of the American College of Surgeons. Dr. Didolkar is

director of surgical oncology at Sinai and associate professor of surgery at Johns Hopkins University. Certified by the American Board of Surgery and a fellow of the Royal College of Surgeons, England, he received his medical degree and master of surgery degree from Nagpur University, India. He has been the principal investigator or co-investigator for numerous funded cancer-related research projects and is the author or co-author of over 75 peer-reviewed published papers. Dr. Didolkar's many professional memberships include the American Association of Cancer Research, American Cancer Society, American Society of Clinical Oncologists, International College of Surgeons, and Baltimore Academy of Surgery.



KENNETH L. GLICK, M.D., a specialist in internal medicine and medical director of the home care and hospice program at Sinai Hospital of Baltimore, has been elected vice chairman of the hospital's medical executive committee. An instructor in the department of medicine at The Johns

Hopkins University School of Medicine, Dr. Glick is a member of the medical honor society Alpha Omega Alpha and the recipient of several awards for medical excellence. He is a member of the American College of Physicians and the American Society of Internal Medicine. Dr. Glick received his medical degree from the State University of New York at Buffalo School of Medicine and served his internship and residency at the Baltimore City Hospitals.



JOHN C. URBAITIS, M.D., F.A.P.A., psychiatrist-in-chief at Sinai Hospital of Baltimore, recently was elected chairman of the hospital's medical executive committee. Dr. Urbaitis, a past president of the Maryland Psychiatric Society, is an assistant professor of psychiatry at The Johns

Hopkins University School of Medicine and a clinical associate professor of psychiatry at the University of Maryland School of Medicine. He is associate editor of *The Maryland Psychiatrist* and founding director of both the Maryland Foundation for Psychiatry and the Maryland Council of Community Mental Health Centers. Dr. Urbaitis received his medical degree from Cornell University Medical College and completed his residency in psychiatry at Henry Phipps Psychiatric Clinic in Baltimore, where he was also a fellow.



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The Baltimore City Medical Society Foundation

The increasing cost of a medical education has become a fact of life. Many physicians still in active practice can recall when tuition for one year at a private institution was less than one thousand dollars and state-supported schools charged only nominal fees to cover laboratory use. Yearly tuition at private medical schools now hovers in the neighborhood of twenty thousand dollars and financial officers claim that covers only part of the cost of educating a student for one year. For the past several years, medical students marching to the dais to receive their medical degrees have carried with them debts as high as fifty thousand dollars.

Recognizing the enormity of such a burden, the Baltimore City Medical Society (BCMS) Foundation has, for the past 20 years, devoted a major portion of its resources to providing need-based scholarships to local medical students. In 1970, the policy and planning committee of the BCMS decided to establish a fund (capitalized from excess income in the society's general fund) that would provide yearly scholarship assistance to a needy graduate of the Baltimore City public school system who successfully pursued a pre-medical education. The first scholarship was awarded in 1971.

It soon became apparent that establishment of a foundation would encourage contributions to the scholarship fund. Articles of incorporation were approved in December 1972, and the Baltimore City Medical Society Foundation, Inc., was born. The foundation's first officers were Douglas G. Carroll, M.D., president; Francis X. Carmody, M.D., secretary; and Nathan E. Needle, M.D., treasurer. The corporation's charter designated the following charitable, educational, and scientific purposes:

1. to further and stimulate research and scientific development in medicine and related sciences;
2. to enhance the quality of medical care;
3. to encourage the elevation of the standards of medical education;
4. to promote and preserve public health; and
5. to promote the study of medicine and research therein, the diffusion of knowledge thereof, and the continuing education of physicians.

In June 1975, an *ad hoc* scholarship committee proposed criteria for the selection of scholarship recipients. The guidelines required that applicants reside in Baltimore City and be currently attending or have a letter of acceptance from a recognized medical school anywhere in the United States. Undergraduate and medical school transcripts would be used to establish applicants' high level of competence in their studies. Applicants also were required to obtain a letter of recommen-

dation from a BCMS sponsor/member and a letter certifying their financial need from the financial aid officer of the medical school.

By April 1976, 20 applications were received for the following academic year. Of these, 15 met criteria for consideration and awards were made to two applicants, Ms. Carla Jansen of Johns Hopkins School of Medicine and Mr. Linwood Koger of the University of Maryland School of Medicine. At the time, the foundation's assets were less than \$3,600.

In subsequent years, foundation board members continued to review applications and made modest awards to as many students as possible (the assistance usually supplements loans and aid from other sources; the foundation's awards are grants that need not be repaid.) The foundation also made small donations to various charitable causes (e.g., the Krause and Kolodner lectureships, the Falls Road Community Center, and the Alliance Against Venereal Diseases). More recently, the foundation has supported the mayor's programs for inner city youth summer activities. It also has donated funds to the Young Physicians Committee for health care for the homeless and Maryland Parents Anonymous.

From its inception, the foundation has received a yearly donation of two thousand dollars from BCMS. It has received many contributions from friends and grateful patients to honor member physicians. From time to time the BCMS auxiliary has made generous donations and many BCMS members have made contributions along with their annual dues; non-dues-paying members also have responded kindly to donation requests. In addition, the foundation has been blessed by the generosity of families and friends who have made major yearly donations to honor the memories of three outstanding physicians, Nathan E. Needle, Elliott R. Fishel, and Kennard L. Yaffee. These donations have become named awards and the recipients are specifically identified by the foundation each spring.

Another source of funding became available in 1991. With the closing of Homewood Hospital, the medical staff voted to donate its entire treasury to the foundation with the stipulation that the foundation broaden the scope of applicants to include qualified students who reside anywhere in Maryland and attend one of its medical schools. As a result of this endowment, the board has awarded one or two scholarships yearly in the names of the medical staff of North Charles General Hospital and Wyman Park Medical Associates.

Membership on the foundation board carries with it a joyous responsibility. Not only are we afforded a small window to look

out upon the scholarship, enthusiasm, and originality of future members of our profession, we help to fulfill the Oath of Hippocrates by assuring the continuity of quality health professionals for our community. We want to express our appreciation to our parent component society, to the membership of the auxiliary, and to the families and friends of honored physicians for their generosity and for the approbation they thus give to such an endeavor. We hope that after two decades of success, during which 90 medical students have received financial assistance, the foundation will serve as a model for medical societies throughout the country and that it will inspire those who have been aided to provide, in turn, assistance to future generations of colleagues.

RONALD HARRISON FISHBEIN, M.D.

Dr. Fishbein is a general surgeon, an associate professor of surgery at the Johns Hopkins University School of Medicine, and a 20-year member of the Baltimore City Medical Society Foundation. ■

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Adriana Zarbin: 1994–1995 alliance president

Adriana Zarbin approaches her year as president of the Med Chi Alliance as she has approached everything in her life—with determination and enthusiasm. She says, “My goals and desires for the Med Chi Alliance are to promote our group as one, to increase our membership, to have our members up-to-date on the latest health system reform issues, to help in the effort to gain tort reform, and to promote the good image of physicians and their spouses.”

Noting that there are many big problems in the world that physicians and their spouses can address and resolve, Mrs. Zarbin points to the publicity recently given to domestic violence as an achievement of the alliance and the medical profession: “We won a small place for domestic violence in our legislature this year, but we must not stop. Our goal is to help stop this violent behavior among the adults as well as our children.”

Mrs. Zarbin believes that alliance members must be team players, going out into the communities to assist where they can do well. She intends to encourage participation by the spouses of physicians just starting into practice: “We must show them that we are one and that we want only the good for their future. Are they not our hope and our future?”

Mrs. Zarbin herself has been an active participant and leader in alliance and community affairs for many years. In addition to numerous activities on behalf of Med Chi, she has served as committee chair, treasurer, secretary, and president of the Baltimore City Medical Society (BCMS) Alliance. Under her leadership, the BCMS Alliance provided support for a variety of the society’s programs, including funding for Health Care for the Homeless and Maryland Parents Anonymous. Active in the mother’s clubs at St. Mary’s Govans elementary school and McDonogh when her children were growing up, Mrs. Zarbin also was 1967–1969 president of Bon Secours Auxiliary, a member of the board of Maryland General Hospital, and president of the Baltimore Opera Guild. She is currently a member of the board of the Opera Guild and a committee chair for the alumnae reunion at the College of Notre Dame of Maryland.

In addition to her role as an activist, Mrs. Zarbin has been a caregiver and nurturer whose main focus has always been her family. Born Adriana Virginia Corasaniti, she and her sister, Marie (now married to William F. Dombrowski, D.D.S.) grew up in northeast



Baltimore, where their parents, Eugene and Rafaella Corasaniti, had settled after emigrating from Italy. Mrs. Zarbin attended St. Dominic’s Elementary School, Notre Dame Preparatory School, the College of Notre Dame of Maryland where she earned her bachelor’s degree in 1954, and the Peabody Preparatory School of Music, where she studied voice.

After completing her studies at Notre Dame, she went to Milan, Italy, accompanied by her mother, to study voice. A career in music was set aside, however, when she met Gino F. Zarbin, M.D. Born in Vittorio Veneto, Italy, Dr. Zarbin had graduated with honors from the University of Milan. Specializing in pediatrics and anesthesia, he was assistant professor at the university hospital in Milan when he met his future bride. The couple married in 1955 at the Basilica of the Assumption in Baltimore, returned to Italy for two years, and then decided that Baltimore would be their home, where they settled in 1957 with their oldest son. Following a three-year residency in pediatrics at the University of Maryland, Dr. Zarbin entered practice as a board-certified pediatrician in 1961.

Mrs. Zarbin counts among her major accomplishments, the achievements of her three sons. Marco, the oldest, is a Phi Beta Kappa from Dartmouth College,

where he graduated summa cum laude with a degree in chemistry. He earned his medical degree as well as a Ph.D. in neuropharmacology from the Johns Hopkins University School of Medicine. He is currently chairman of the department of ophthalmology at the University of Medicine and Dentistry of New Jersey in Newark. His wife, Christine, is associate professor of classics at Emory University in Atlanta, Georgia. The Zarbins' middle son, Sergio, chose his uncle's profession, dentistry. After graduating from Loyola College in Baltimore, he earned his D.M.D. from the Goldman School of Dentistry of Boston University. He practices in Baltimore and Hagerstown. Youngest son Robert, who also earned his undergraduate degree at Loyola in Baltimore, graduated from Loyola University law school in New Orleans, Louisiana. He now practices law, and with his wife, Cynthia, lives in the Baltimore area.

Having successfully encouraged her children to reach for high goals, Mrs. Zarbin is well qualified to inspire alliance members to work hard: "It's such a big world with big problems, and yes, we are a small group. But, no matter how small, we can win, we can do it. Together, with one team, we can make a change in drug abuse, domestic violence and abuse to our young, and the violence on our streets. The operative words are **together and as one.**"

Mrs. Zarbin's message this year will be solidarity, unity, and shared vision. As her guide, she quotes from a speech given by American Medical Association Alliance president-elect Barbara Tippins: "To have every physician's spouse feel ownership in the medical alliance as the organization capable of having an impact on the issues that are vital today. . . to have them realize that the possibility and the privilege of speaking out about these issues becomes a reality when they join the medical alliance." ■

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In Memoriam

George M. Baumgardner, M.D., a general practitioner who retired in 1976 from his 44-year practice in the Rosedale area of Baltimore County, died of respiratory failure at Carroll County General Hospital, March 5, 1994. He had lived at the Carroll Lutheran Village retirement community in Westminster since 1986. After attending Mt. St. Mary's College and completing his undergraduate work at the University of Maryland in 1926, Dr. Baumgardner worked as a streetcar conductor and at other jobs to put himself through the University of Maryland School of Medicine, where he earned his medical degree in 1930. He completed his internship at the-then Mercy Hospital and his residency at Saint Joseph Hospital. Continuing to make house calls even at the end of his career, Dr. Baumgardner did his own laboratory work, took and developed his own x-rays, and delivered more than 5,000 babies, including a set of quintuplets. Dr. Baumgardner was 92.

Luis F. Bentolila, M.D., a Bethesda internist and assistant clinical professor at George Washington University School of Medicine, died at Suburban Hospital, March 24, 1994, of kidney cancer. Born in Buenos Aires, Argentina, Dr. Bentolila received his medical degree from the University of Buenos Aires medical school. Moving to the United States in 1967, he completed his internship at Prince George's Hospital Center and his residency in internal medicine at Washington Hospital Center. Before moving his offices to Bethesda in 1985, Dr. Bentolila had practiced in Chevy Chase. In addition to his private medical practice, Dr. Bentolila was a pilot who served as a medical examiner for the Federal Aviation Administration. Dr. Bentolila was 51.

Lester H. Caplan, M.D., a retired Baltimore County pediatrician, died March 18, 1994, of complications from a heart attack. A 40-year member of the Medical and Chirurgical Faculty of Maryland, Dr. Caplan was a graduate of the Johns Hopkins University. He earned his medical degree with honors at the University of Maryland School of Medicine in 1940, and completed his internship at University Hospital. During World War II, he served with distinction in the Army Medical Corps in Europe, winning the Soldier's Medal for rescuing crew members from a crashed and burning airplane. Following the war, Dr. Caplan completed his residency at University Hospital, then opened an office on Eutaw Place and later in Pikesville, where he continued his

medical practice until retiring 10 years ago. After his retirement, he examined disability claims for the Social Security Administration. Dr. Caplan was 77.

Corinne Cooper, M.D., a dermatologist and internist who practiced in Rockville, Montgomery County, died at her home, February 26, 1994, of a stroke. Born in Washington, DC, Dr. Cooper was valedictorian of McKinley Technical School. She received her bachelor's degree in 1928 and her medical degree in 1937 from George Washington University. She was a member of the American Medical Association, an emeritus member of the Medical and Chirurgical Faculty of Maryland, and a member of the Smith Reed Russell Honorary Society. Dr. Cooper also had a long-standing association with Chestnut Lodge. She was 88.

Alfred S. Garrison, M.D., a retired Baltimore surgeon, died at his home in Catonsville, April 23, 1994, of cancer. Dr. Garrison was a former chief of staff and chairman of the department of surgery at St. Agnes Hospital, where he was responsible for the surgical education program. He maintained offices at St. Agnes as well as Bon Secours Hospital until his retirement in 1986. Dr. Garrison earned his bachelor's degree at Western Maryland College in 1940, and his medical degree in 1943 at the University of Maryland School of Medicine, where he belonged to the Benjamin Rush Society. A U.S. Navy lieutenant during World War II, he served as a physician in the Pacific theater of operations. Dr. Garrison was a fellow of the American College of Surgeons and an emeritus member of the Medical and Chirurgical Faculty of Maryland. An instrument-rated pilot, he was a member of the Quiet Birdmen, a Baltimore flying club, as well as the Boumi Temple, the Scottish Rite, the Jesters, and Mount Ararat Lodge No. 44 in Bel Air. Dr. Garrison was 74.

Jeremy D. Hallisey, M.D., an anesthesiologist at Mercy Medical Center, died at his home in Arnold, March 21, 1994, of cancer. Born in Hassocks, Sussex, England, Dr. Hallisey was educated at St. Augustine's College, Cambridge College of Arts and Technology, and Charing Cross Hospital Medical School. He received his medical degree from the University of London in 1974. He practiced emergency medicine in Nassau, Bahamas, before completing his residency in anesthesiology at the University of Maryland in 1976. Following a return to England in 1978 for further study, Dr. Hallisey practiced



in Fort Lauderdale, Florida, and at University of Maryland Hospital in the early 1980s. A member of Mercy Anesthesiologists Associates, he had been associated with Mercy since 1990. Dr. Hallisey was 43.

Paul G. Koukoulas, M.D., a Baltimore County internist, died April 10, 1994, after an apparent heart attack at his home. He had practiced internal medicine in Dundalk since 1963, and was a member of the staffs of Franklin Square and Church hospitals. Dr. Koukoulas was born on the Greek island Rhodes, moved to Baltimore at age 16, and graduated from Patterson Park High School and Western Maryland College. After receiving his medical degree from the University of Maryland School of Medicine, Dr. Koukoulas completed his internship at St. Agnes Hospital and his residency at Fort Howard Veterans Hospital. An Archon of the Ecumenical Patriarchate of Constantinople of the Order of St. Andrew, he was a former president of the parish council at both St. Demetrios Greek Orthodox Church and at St. Nicholas Greek Orthodox Church. Dr. Koukoulas was 61.

Zsigmund J. Toth, M.D., a Baltimore obstetrician and gynecologist who retired in 1984, died of heart failure March 14, 1994, at his home in Bolton Hill. A native of New York City, Dr. Toth earned his bachelor's degree in 1940 from Louisiana State University and his medical degree from LSU medical school in 1943. Completing his internship at the Chelsea Naval Hospital, Boston, Massachusetts, Dr. Toth served in the Pacific theater of operations during World War II, then practiced general medicine from 1946 to 1948 in Green Bay, Wisconsin. After completing a residency in obstetrics and gynecology in 1954, he opened his office on Park Avenue in Baltimore, where he practiced until his retirement. In 1971, Dr. Toth temporarily gave up his medical practice to cross the Atlantic Ocean with his wife in their 42-foot ketch. During the three-year voyage, the couple sailed to Bermuda, the Azores, and the Greek islands. In addition to his expertise as a navigator, Dr. Toth played violin, viola, and oboe, often appearing with the Hopkins Symphony Orchestra and the UMBC orchestra. Dr. Toth was 77.

No additional information was available at press time for the following members:

David Andrew, M.D.
Baltimore County, January 10, 1994

Maxie T. Collier, M.D.
Baltimore City, April 22, 1994

Alexander Dick, M.D.
Kent County, January 17, 1994

David S. Gordon, M.D.
Prince George's County, January 30, 1994

Ferenc Gyorkey, M.D.
Affiliate, July 1993

Lloyd Hughes, M.D.
Prince George's County, February 1, 1994

Leon A. Kochman, M.D.
Baltimore City, October 29, 1993

Henry C. Mellette, M.D.
Montgomery County, March 15, 1994

Reginald H. Mitchell, M.D.
Montgomery County, March 14, 1994 ■

PRACTICE ISSUES

Guidelines for evaluation and management of people with seizures and epilepsy.

Professional Advisory Board, Epilepsy Association of Maryland, Inc.
The Epilepsy Association of Maryland, Inc., is an affiliate of the Epilepsy Foundation of America.

A seizure is an alteration in a person's behavior or motor or sensory function with or without loss of consciousness due to an abnormal neuronal discharge within the central nervous system. Epilepsy is a condition characterized by a tendency for recurrent seizures unprovoked by any known proximate insult. Seizures due to congenital abnormalities or vascular or neoplastic processes may be recurrent and, therefore, constitute epilepsy. Febrile seizures are considered a special class of seizures limited to children.

The patient with a single episode

Diagnosis. The diagnosis of a seizure depends on an accurate history and description of the event and the circumstances under which it occurred. There is no other way of diagnosing a seizure other than direct observation of the event as it occurs or with video monitoring. By the end of an appropriate history, the physician should be able to say that the event in question was a seizure, that it clearly was not a seizure, or that its nature is uncertain.

Evaluation. Further evaluation of the event will depend on the physician's interpretation of the history, the patient's prior history, the age of the patient, and the patient's physical and neurological findings.

Electroencephalogram (EEG). The EEG neither diagnoses nor rules out that the prior event was a seizure. An EEG is generally obtained after a first seizure or suspected seizure to identify epileptogenic potentials (focal or generalized) and to assist in determining prognosis and management. There are circumstances in which it need not be obtained (for example, in uncomplicated febrile seizures in young children).

When the EEG is obtained, awake and sleep recording, photic stimulation, and hyperventilation should be performed when possible. Hyperventilation may be contraindicated because of age or cardiovascular or respiratory problems.

An EEG should be repeated when, and only when, there is a change in seizure pattern or neurologic condition or when the EEG will alter decisions about treatment. There is no need to repeat the EEG at routine intervals. An EEG done when medication discontinuation is being considered may assist in predicting the likelihood of seizure recurrence.

Brain imaging. Computed tomography (CT) and magnetic resonance imaging (MRI) scans screen for brain abnormalities that may have caused a seizure. They need not be performed routinely in every patient. Younger individuals without evidence of clear neurologic focality or evidence of acute trauma do not necessarily need a scan at the time of the first seizure. Children with febrile seizures rarely need to be scanned. Scans in adolescents or adults should be performed if the physician is concerned about an acute or a progressive process. MRI scans provide better definition of subtle abnormalities and may be preferable in specific cases.

Laboratory assessment. The need for complete blood counts, blood chemistries, metabolic evaluation, toxicology screening, and lumbar punctures should be based on the patient's history, physical examination, and clinical condition.

Management. Every individual who presents with a single episode requires appropriate counseling and discussion. The nature of the counseling will depend on the physician's interpretation of the event, its cause, and its likelihood of recurrence. This discussion provides the patient and the family with accurate information and helps to alleviate anxiety. Driving and other safety issues should be discussed.

Antiepileptic medication may or may not be required after a single seizure. Decisions about treatment require evaluation of the risks and benefits of the medication and of the chance and consequences of a seizure recurrence. These risks vary with age, job, and other factors. The final decision about treatment should be the result of a dialogue between the patient and the physician. If medications are utilized, monitoring of efficacy and side effects (discussed below) is essential.

The patient with recurrent episodes

Diagnosis. As with a single seizure, recurrent episodes may or may not be due to epilepsy. Decisions require continued evaluation of the circumstances and nature of the events.

EEG. The EEG should be repeated when it can assist in making a therapeutic decision. Progressive or changing neurologic findings or evolving patterns of seizures may be indications for repeating the EEG or for more extensive monitoring. The EEG also may be useful in defining epilepsy syndromes that may require specific therapy or have prognostic implications (e.g., infantile spasms, juvenile myoclonic epilepsy, and benign rolandic epilepsy).

Ambulatory EEG monitoring. When doubt remains about the nature of the events, and when the events are sufficiently frequent, ambulatory monitoring may, on occasion, permit correlation of EEG events with the episodes reported by the patient or the family. Ambulatory monitoring also may assist in

PRACTICE ISSUES

the differentiation of fainting or cardiogenic spells and pseudo-seizures from true epileptic events.

Video-EEG monitoring. Video-EEG monitoring is the best available method for documenting and defining seizure types. It should be used when the nature of the frequent episodes is unclear or when localization of seizures is needed in a pre-surgical evaluation.

Brain imaging. When a scan is indicated in the person with recurrent episodes, an MRI is the preferred test because it will detect subtle abnormalities. It is rare that an individual needs both a CT scan and an MRI.

Positron emission tomography (PET) scans/single photon emission computed tomography (SPECT) scans are not part of the routine evaluation of patients with epilepsy. In highly selected situations, especially when surgery is being considered, they may provide confirmation of focal dysfunction.

Psychosocial management. Every person who has been diagnosed with epilepsy requires accurate information and appropriate counseling, since misconceptions remain prevalent. The physician must discuss the diagnosis, the meaning of the test results, the risks of recurrence, and other prognostic issues. The choice of antiepileptic medications and their possible side effects should be reviewed. Driving, other safety issues, pregnancy, and birth control should be discussed. The Epilepsy Association of Maryland can help in providing the patient with supplementary information and counseling. Neuropsychological testing can be useful for evaluating the cognitive and emotional problems associated with epilepsy.

Medical management. The medical management of epilepsy requires analysis of the likelihood and potential consequences of a recurrent seizure. The risks of a recurrent seizure will depend on the type of seizure, the timing of the seizure, the age of the patient, the patient's occupation, and many other factors. These should be weighed against the chances and consequences of adverse medication effects. The patient (or family) must determine which risks are acceptable; not all patients have to be on medication.

The goal of antiepileptic drug therapy is the complete suppression of seizures while avoiding intolerable side effects, including cosmetic and cognitive changes. The definition of intolerable should be made by the patient, not the physician. The choice of medication will be guided by the patient's seizure type or syndrome, the patient's age, behavior, and the pharmacologic properties and cost of the medication. Family planning and pregnancy require special consideration.

Blood levels. Published "therapeutic" serum antiepileptic blood levels may provide useful guidelines. However, the lower end of the "therapeutic range" for these medications merely

indicates the level at which the drug is likely to be effective and the upper end of the range indicates the level at which side effects are more likely to appear. Therapeutic ranges are guides, not limits. Some patients achieve seizure control with blood levels below, and others with blood levels above, these ranges. Monotherapy is generally preferable to polytherapy because it results in fewer side effects.

Other laboratory tests. Complete blood counts, blood chemistries, and other tests need not be performed routinely. They are useful when initiating therapy and whenever the patient's history or condition raises concerns.

Return visits. The frequency of return visits should be determined by the frequency of the patient's seizures and the need to alter medications. Many medication changes can be done by telephone. Patients whose seizures are well controlled may only need to be seen at 6- to 12-month intervals. Those with more frequent seizures or new side effects may need to be seen more often. EEGs and laboratory tests need not be part of every return visit. Psychosocial issues including employment, family problems, and school or work performance should be screened at each visit. Other professionals and outside agencies should be consulted when appropriate to optimize the patient's quality of life.

Referrals. Patients whose seizures remain intractable to two standard medications that have been increased to maximally tolerated levels and those who demonstrate progressive symptoms should be referred to a center or an individual specializing in epilepsy where other options, such as surgery, can be considered.

This information is copyrighted by the Epilepsy Association of Maryland, Inc., and printed in the Maryland Medical Journal with permission. For additional information, contact the Epilepsy Association of Maryland, Inc., 300 East Joppa Road, Suite 1103, Towson, MD 21286-3018; telephone 410-828-7700.

Reprints: Lee Ann Kingham, Executive Director, Epilepsy Association of Maryland, 300 E. Joppa Road, Suite 1103, Towson, MD 21286. ■

We Agree.

Every state medical society, 64 medical specialty societies, and the American Medical Association agree that any health system reform legislation must contain the principles outlined in the letter below:

February 23, 1994

Dear Senator/Representative;

As physician organizations, we agree on the need for health system reform legislation that gives every American universal coverage for health care and effectively controls rising health costs, while ensuring quality patient care. These principles have been articulated by numerous medical organizations in their various health system reform policies and proposals. They remain the foundation of our legislative agenda, which is to enact laws that assure universal coverage for a standard set of health benefits, regardless of employment or economic status.

We believe that any measure adopted by the Congress should:

- Achieve universal coverage through a program where responsibility is shared by employers, individuals, and government in paying for health care coverage.
- Assure that every American has his/her choice of health plans, physicians, and other providers.
- Establish competition in the marketplace as a method of slowing the rate of growth in health spending.
- Give patients price and quality information to permit them to make informed decisions.
- Eliminate needless bureaucracy to create an efficient, streamlined, and coordinated system that minimizes red tape for patients, physicians, and other providers. Furthermore, health system reform must leave medical decision-making in the hands of physicians and their patients.

We believe that to enable physicians to best serve the interests of their patients, meaningful health system reform also must contain these elements:

- Significant antitrust relief that enables physicians to have a strong voice to balance the growing corporate and government domination of health care.
- Allow for physician-directed health care networks.
- Enhanced self-regulatory powers that would enable the profession to effectively police itself and its members without the threat of unwarranted litigation.

We also believe that major reforms in the professional liability system must be enacted, including a \$250,000 cap on non-economic damages, limits on plaintiff attorneys' fees, and other measures that would minimize defensive medicine.

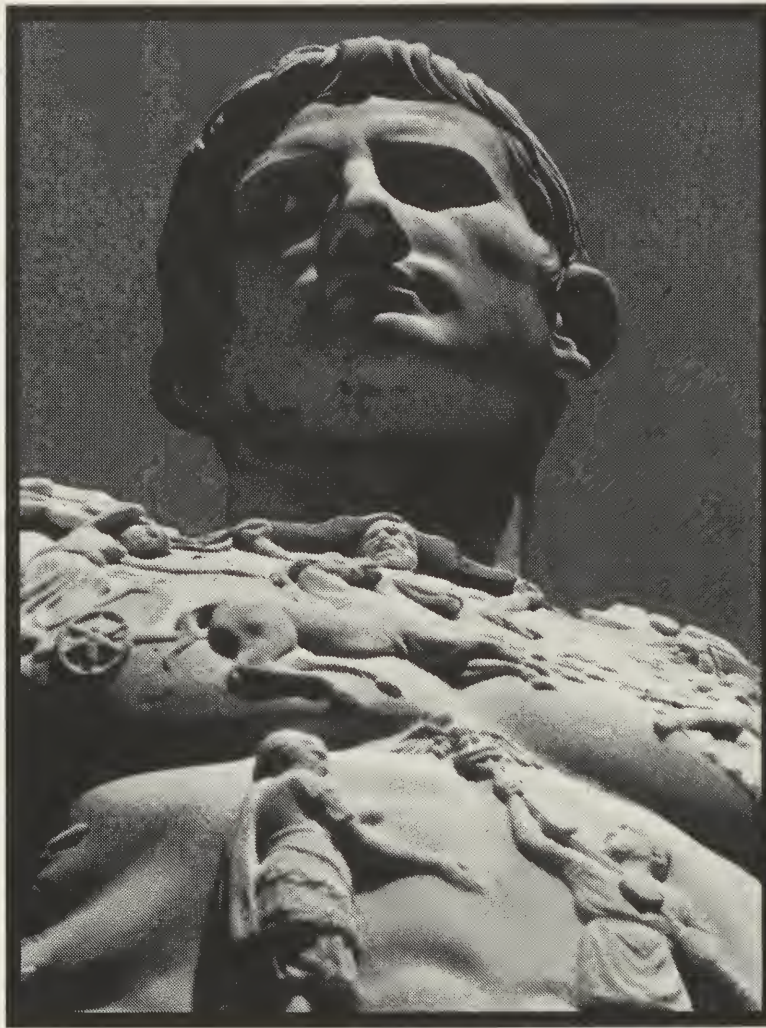
Every American will be affected by this legislation. The focus of policy-makers should be on how their decisions will affect patient care. Any system that raises significant barriers between patients and physicians will not provide the quality care our nation expects and deserves. We believe the above principles outline a framework for establishing constructive, effective, and needed health system reform.

Join your colleagues in your county and state medical societies and the AMA. And stand with the organizations that stand behind you.

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Physicians dedicated to the health of America



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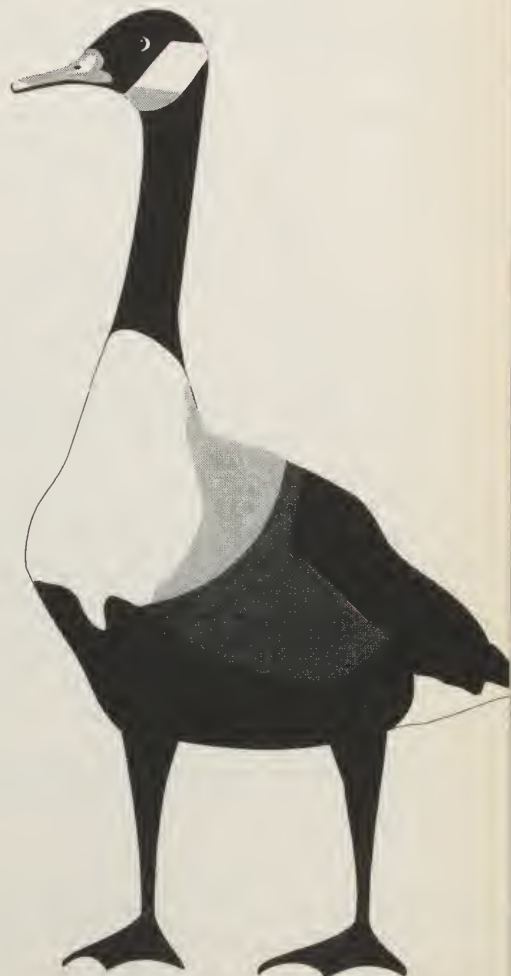


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September 9, 1994
thru Sunday,
September 11, 1994
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deadline is August 25, 1994, but rooms may
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The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

Letter of transmittal—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

Manuscript preparation—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

References—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

• **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

• **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

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- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
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- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

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Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

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| | |
|--|---------|
| Dermatosis of pregnancy | July 7 |
| Tumor conference | July 14 |
| Recent perinatal advances in the evaluation of the fetus | July 28 |

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

| | |
|---|-------------------------------|
| Johns Hopkins third annual update on obstetric anesthesia plus an optional fiberoptic airway management workshop. 12 Cat 1 AMA/PRA credits. Fee: \$275/physicians; \$75/residents and fellows; one-day fees available. | Aug. 13-14 |
| Ophthalmology for the pediatrician. Cat 1 AMA credits available. Fee: \$125/physicians; \$95/residents, fellows and allied health professionals. | Sept. 16 |
| Airway management: Hands-on workshops, case management colloquia, and difficult airway/intubation alert. Cat 1 AMA/PRA credits available. Fee: \$650. | Sept. 23-25 |
| Pediatrics for practitioner update '94. 14 Cat 1 AMA credits. Fee: \$290/physicians; \$190/residents*, retired physicians, allied health professionals, fellows* (with letter). | Sept. 29-30 |
| 20th anniversary: Annual topics in gastroenterology and liver disease. Cat 1 AMA/PRA credits available. Fee: \$495/physicians; \$250/residents and fellows (with letter from department chairperson verifying status). | Oct. 5-7 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA/PRA credits available. Fee: \$500/lectures; \$400/each additional lab; \$200/lectures for fellows and allied health professionals. | Oct. 24-26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250/presymposium workshop; \$450/symposium; \$250/residents and full-time students. | Oct. 27-30 |
| Advanced pediatric life support courses. 20 Cat 1 AMA credits. Fee: \$525. | Oct. 31-Nov. 2; June 12-14 |
| Advances in pediatric nutrition, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: \$200/physicians and allied health professionals; \$150/residents and fellows. | Nov. 14-16 |
| Memory and reality: Reconciliation scientific, clinical and legal issues of false memory syndrome, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: Postmarked before Oct. 1: \$300/professionals; \$125/families (includes 2 family members), postmarked after Oct. 1: \$400/professionals; \$275/families (includes 2 family members). | Dec. 9-11 |

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The Johns Hopkins Medical Institutions (continued)

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Managing emergency medical services, at the University of Maryland Baltimore County. **July 5-29**
Info: Dr. Richard Bissell 410-455-3776.

Endocrinology update for the practicing physician 1994, at Harrisons Pier 5, Baltimore, MD. **Oct. 7-8**
10 Cat 1 AMA credits. Fee: \$175/physicians; \$100/residents and fellows. Info: Dorothy Taylor 410-328-2515.

R. Adams Cowley 16th annual national trauma symposium, at the Hyatt Regency, in **Nov. 16-20, 1994**
Baltimore, Maryland. Info: 410-328-2399.

Miscellaneous meetings

Trials and Deliberations in Medicine. Attendants receive a 5% discount on 1995 Med Mutual renewal premiums and 2 Cat 1 AMA/PRA credits. Fee: \$40.00. Info: Toni Davis or Natalie Harper at 410-785-0050:

| | |
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| Suburban Hospital, Bethesda | July 5 |
| Memorial Hospital, Cumberland | July 6 |
| Peninsula General Hospital, Salisbury | July 7 |
| Medical Mutual, Hunt Valley | July 14 |
| Montgomery General Hospital, Olney | July 20 |
| Medical Mutual, Hunt Valley | July 26 |
| Patuxent Medical Group, Columbia | July 28 |
| Ramada Inn, Hagerstown | Aug. 4 |
| Medial Mutual, Hunt Valley | Aug. 9 |
| Med Chi, Baltimore | Aug. 16 |
| Kent/Queen Anne's Hosp., Chestertown | Aug. 18 |
| Shady Grove Hospital, Rockville | Aug. 23 |
| Columbia Conference Center, Columbia | Aug. 24 |

Miscellaneous meetings (continued)

| | |
|--|----------|
| Liberty Medical Center, Baltimore | Aug. 25 |
| Medical Mutual, Hunt Valley | Aug. 30 |
| Patuxent Medical Group, Columbia | Sept. 1 |
| Harford Memorial, Havre de Grace | Sept. 6 |
| Medical Mutual, Hunt Valley | Sept. 7 |
| Anne Arundel Med. Ctr., Annapolis | Sept. 8 |
| Medical Mutual, Hunt Valley | Sept. 12 |
| Doctor's Comm. Hosp., Lanham | Sept. 13 |
| Holy Cross Hosp., Silver Spring | Sept. 20 |
| Medical Mutual, Hunt Valley | Sept. 21 |
| Frederick Memorial, Frederick | Sept. 22 |
| Annual meeting of the Bollvian Medical Society , sponsored by the George Washington University Medical Center, in Arlington, Virginia. Info: Todd Belfield, 202-994-4285. | Aug. 4-7 |
| Women's health research topic , sponsored by the Baltimore City Medical Society at the Montebello Rehabilitation Hospital. 1 Cat 1 AMA Credit, Fee: Free. Info: 410-625-0022. | Sept. 1 |



PHYSICIAN'S RECOGNITION AWARD

During May 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Khalid A. Abousy, M.D.
Manoochehr Arfaa, M.D.
Paul D. Barnes, M.D.
Chhabi Bhushan, M.D.
Clifford K. Boese, M.D.
Edwin K. Burkett, M.D.
James T. Burns, M.D.
Amy J. Byer, M.D.
Bart Chernow, M.D.
Thomas E. Dooley, M.D.
Gerald Felsenthal, M.D.
Eric Finzi, M.D.

Edmund J. Forte, M.D.
Joseph A. Fortuna, M.D.
Melvin M. Friedman, M.D.
Christopher A. Friedrich, M.D.
Clarence W. Gehris, M.D.
David H. Grossman, M.D.
Donald R. Haggerty, M.D.
Karl D. Hawver, M.D.
Colen C. Heinritz, M.D.
Lien A. Hung, M.D.
Christopher Y. Kim, M.D.
Robert F. Larkin, M.D.

Joy D. Leverich, M.D.
Thomas F. Magovern, M.D.
Jeffrey A. Martin, M.D.
Rose M. Mulaikal, M.D.
A. Frederick North, M.D.
Dennis S. Pacl, M.D.
W. J. Pawlak, M.D.
Gordon W. Price, M.D.
Soma N. Reddy, M.D.
Albert S. Rudock, M.D.
Ernie D. Swanson, M.D.
Stephanie Trifoglio, M.D.

Miscellaneous meetings (continued)

- Diabetic retinopathy: A comprehensive review and update**, sponsored by The American Diabetes Assoc. and The Retina Institute of MD, at the Stouffer Harborplace Hotel, Baltimore. 7.5 Cat 1 AMA Credits. Fee: \$275/physicians, \$100/fellows, residents, and allied health professionals. Info: 410-337-4500. **Sept. 23**
- Hematology board review course**, sponsored by the George Washington University Medical Center, at the Ritz-Carlton, in Pentagon City, Virginia. Info: Maria Gorrick, 202-994-4285. **Oct.**
- Network approach to provision of health care**, sponsored by the Baltimore City Medical Society at the Good Samaritan Hospital. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. **Oct. 6**
- Psycho-economics: Clinical psychiatry and health care reform in the 1990s**, sponsored by the American Psychiatric Association, in Baltimore, Maryland. 34 Cat 1 AMA/PRA credits. Info: 202-682-6174. **Oct. 8-12**
- Second annual gynecology CME course**, at the Plaza Hotel in NY, 13.5 Cat 1 AMA credits. Fee: \$495/physicians; \$295/physicians-in-training and allied health professionals. Info: Svetlana Lisanti, 201-385-8080. **Oct. 15-17**
- Annual business meeting**, sponsored by the Baltimore City Medical Society at UMMS Davidge Hall. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. **Nov. 3**

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month, 8:00-9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

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The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

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410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a résumé to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

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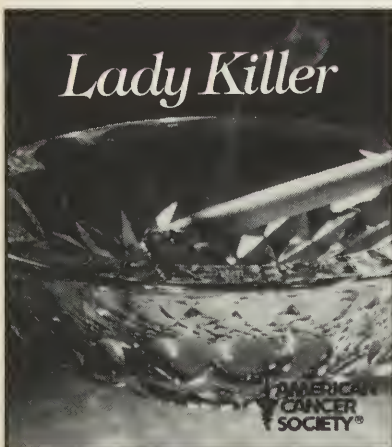
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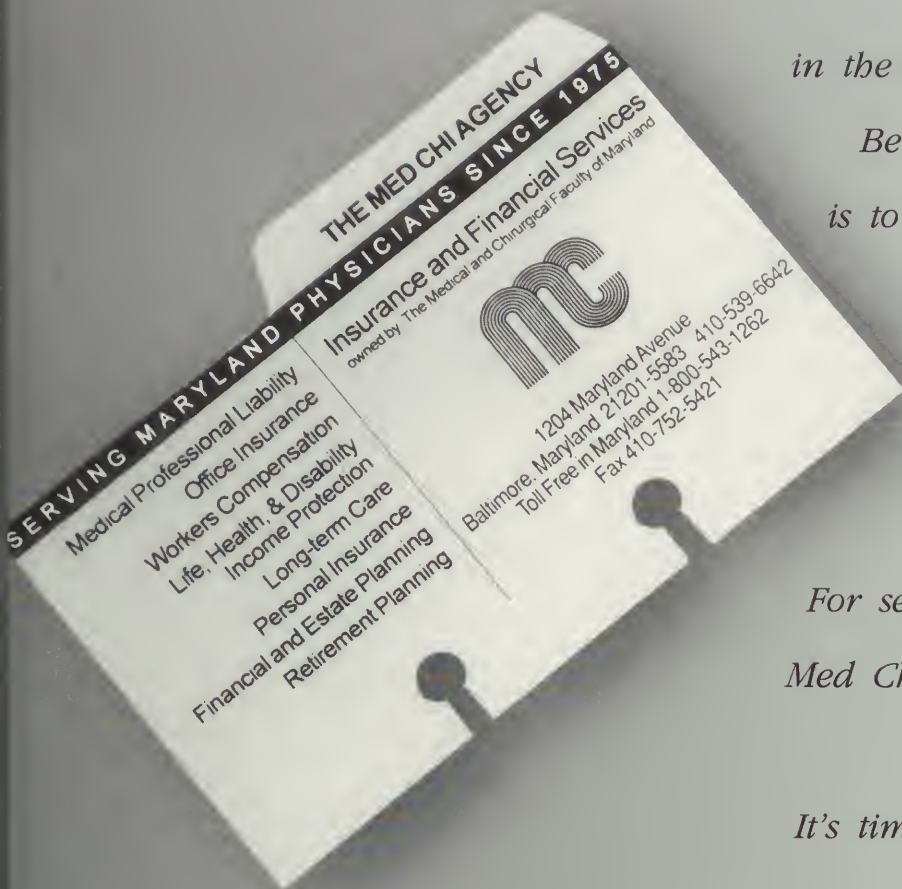
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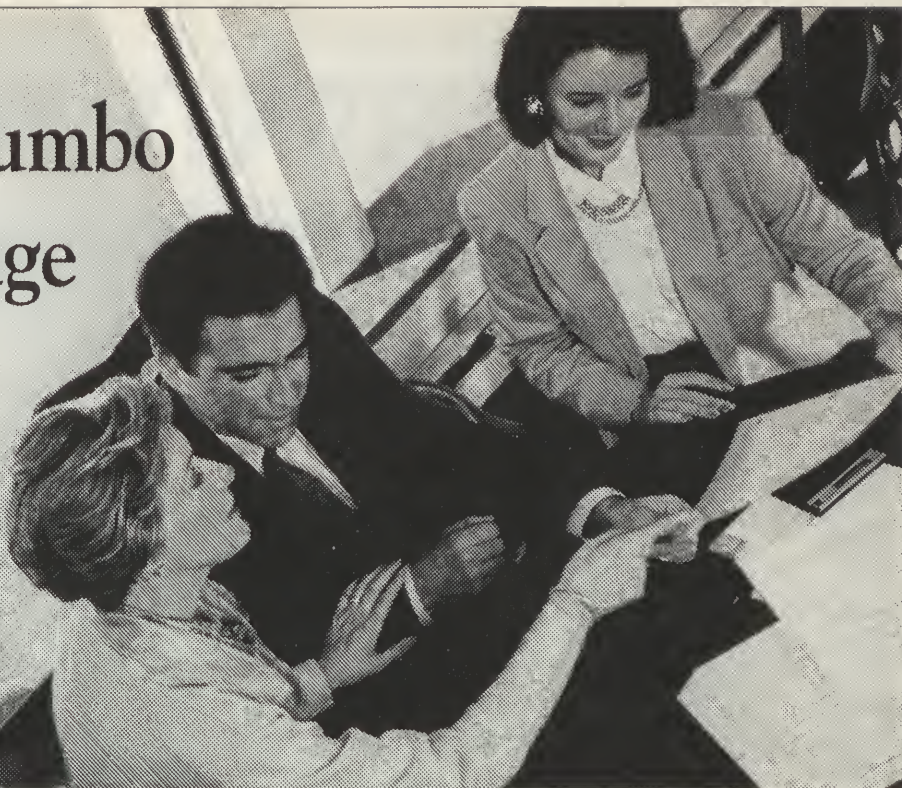
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Medical
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Case # 26

A 25-year-old jockey developed acute wrist pain and swelling following a fall from a horse.

DIAGNOSIS: Radial bone bruise and extensor tenosynovitis.

The conventional radiograph (figure 1) reveals no evidence of fracture. The coronal T1-weighted MR image (figure 2) demonstrates a focal marrow abnormality (arrowheads), indicative of a bone bruise involving the distal radius. The axial T2-weighted MR image (figure 3) reveal bright signal intensity fluid distending the extensor carpi radialis longus and brevis tendon sheaths (arrows), surrounding the dark extensor tendons.

Bone bruises (marrow edema with micro-trabecular fractures) and some non-displaced fractures remain undetectable on plain radiographs. MRI is extremely sensitive to alterations in marrow signal intensity and, therefore, these painful yet radiographically-occult injuries are readily recognized. MRI also represents the examination of choice in detecting and grading the severity of soft tissue injuries. In this case, traumatic tenosynovitis was accurately differentiated from actual tendon disruption.



FIGURE 1



FIGURE 2

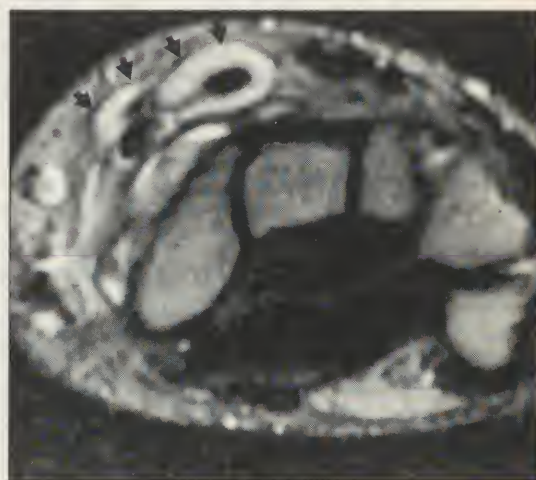


FIGURE 3

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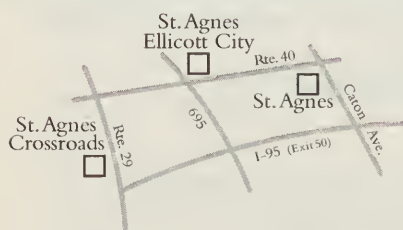
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Chief Executive Officer's Newsletter

July 1994

Preliminary Program for Semiannual Meeting

The preliminary program and registration form for the 1994 Med Chi Semiannual Meeting, being held at the Sheraton Ocean City Resort and Conference Center, September 9 - 11, 1994, follows this issue of the *Chief Executive Officer's Newsletter* (CEON). If you have any questions about the meeting, please contact the Med Chi communications department at 410-539-0872 or 1-800-492-1056.

Independent Practice Association

A memorandum from Allan D. Jensen, M.D., chairperson, Ad Hoc IPA Committee, which details the progress in the development of a statewide network, immediately follows the CEON on pages 559 and 560.

Med Chi House of Delegates

The first meeting of the Med Chi House of Delegates under the new bylaws was held Thursday, July 21, 1994, at Med Chi. William C. Richardson, Ph.D., chairperson, Health Care Access and Cost Commission (HCACC), and John M. Colmers, executive director, HCACC, provided the keynote address for the House of Delegates. There were 152 delegates, alternate delegates, and guests in attendance.

Meetings of the reference committees were held early in the day. Reference Committee A, chaired by J. David Nagel, M.D., heard testimony on fourteen resolutions and the Reference Committee on Bylaws, chaired by Arthur T. Keefe, Jr., M.D., heard testimony on eight resolutions. Reports of the reference committees were presented to the House of Delegates. Look for a full report of the reference committee recommendations and decisions by the House of Delegates in a future issue of the *Maryland Medical Journal*.

Medicare Billing

Some Medicare parenteral/enteral nutrition (PEN) patients are reportedly receiving an excessive number of irrigation kits and Medicare is being billed for these kits.

This situation is occurring in some instances because a supplier is billing the PEN Medicare carrier (there are only two carriers in the country) for gastrostomy irrigation supplies using "B" codes, while Medicare is concurrently being billed for the same patient, for ostomy irrigation kits, through the local carrier, under "A" codes. Medicare carriers processing these claims will take action in an effort to ensure that they do not pay for supplies that are not reasonable and necessary and to determine whether duplicate payments are being made.

The following "A" HCPS codes have been identified as being billed with "B" codes for the same patient: 1. Appliances and related supplies for the management of urinary incontinence (A4310-A4359; K0132-K0126; XX004-XX005). 2. Supplies related to the management of an ostomy (A4361-A4421; A4454-A4455; A5051-A5149); K0137-K0139; XX006-XX008). The "B" codes for supplies related to the administration of enteral nutrition are B4034-B4036 and B9998. Ostomy supplies are typically covered only for use on patients with an ostomy, which is a surgically created opening (stoma) to divert urine, feces, or ileal contents outside the body.

Should you become aware of situations where you believe Medicare may be inappropriately reimbursing for irrigation kits or related supplies, please contact Don Nicholson, Medicare fraud and abuse information coordinator, BCBS Maryland, Medicare Division, at 410-561-7976.

Calling All Medical Musicians

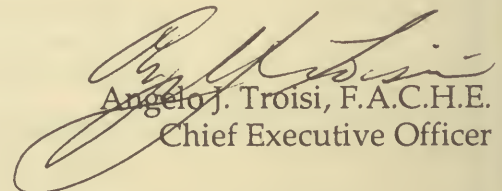
VA-National Medical Musical Group (VA-NMMG) is recruiting new members for its chorus and symphony orchestra. If you sing or play a musical instrument you may apply. VA-NMMG plans to give its annual concert November 9, 1994, at the John F. Kennedy Center for the Performing Arts in Washington, DC. Following that, the group will conduct a concert tour of Italy, November 10-18. Participation is open to physicians, nurses, other medical personnel, and students, both VA and non-VA. The tour of Italy will cost \$1,362 including airfare, first class hotels, sightseeing, all breakfasts, and most dinners. For information on auditions or travel to Italy as a VA-NMMG performer or companion, write to VA-NMMG, P.O. Box 50-149, Washington, DC 20091-0149 or call Mrs. Nevart Haley at 202-667-3879.

Study Group in Alternative Medicine

The next meeting of the Study Group in Alternative Medicine will be held on Wednesday, October 12 at 7:30 p.m. in the Krause Room at Med Chi. Michael H. Kahn, Ph.D., will present an overview of the use of clinical hypnosis with medical problems. Dr. Kahn is a clinical and health psychologist in private practice who specializes in using the principles of psychology to promote and maintain health, to prevent and treat illness, and to foster rehabilitation. He uses clinical hypnosis extensively.

The study group serves to foster awareness and knowledge of the diverse techniques being used in alternative medicine. At each meeting a speaker presents a brief overview of his or her area of expertise, which is followed by a question and answer/discussion period among the attendees. Previous speakers have included: David Larson, M.D., of the Office of Alternative Medicine at the National Institutes of Health; Brian Berman, M.D., director of the Laing-University of Maryland at Baltimore Complementary Medicine Project, and; Leonard A. Wisneski, M.D., clinical professor of medicine at George Washington University School of Medicine.

Faculty members, their colleagues, and other health care professionals are cordially invited to attend. For further information, please call Hiroshi Nakazawa, M.D., at 410-644-1502 or Steve Jones at 800-492-1056.


Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

MEMORANDUM

TO: All Members
FROM: Allan D. Jensen, M.D.
Chairperson, Ad Hoc IPA Committee
DATE: July 11, 1994
RE: Progress in Development of Statewide Network

At the House of Delegates annual meeting in May, the following recommendations of the Ad Hoc Committee for Establishing an IPA were approved:

- Recommendation 1: Med Chi should adopt a multi-faceted strategy for managed care, including the creation of a new entity for managed care contracting.
- Recommendation 2: The new entity should:
- a. develop a statewide network that links individual physicians and groups with existing IPAs and physician components of PHOs;
 - b. market the network to HMOs, PPOs, insurers, self-funded employers and unions, and units of government on a regional or county basis;
 - c. acquire managed care administrative services to support IPA/PHO operations.
- Recommendation 3: In addition to the activities of the new entity, Med Chi should:
- a. evaluate managed care plans;
 - b. sponsor managed care physician education.

Our committee and Med Chi staff have been working diligently to make these recommendations a reality. On June 6, 1994, an implementation plan and budgets were presented to us by our consultants, Eastwest Research Corporation. The plan was tentatively accepted, pending further discussion on budgetary levels and financing options.

On June 21, 1994, our consultants provided a critical path analysis and time frames for network development. We are now in the process of refining the development plan and budgets.

Our consultants have advised us that the development and introduction of a statewide network will be a complex, lengthy, and expensive process. Lawyers, actuaries, and consultants will work together to form a corporation; establish its governance; develop necessary contracts; develop operational capabilities to manage utilization and financial risk; establish risk and non-risk compensation mechanisms; establish clinical and operational policies; design marketing approaches and collateral materials; and launch operations.

The financing of the statewide network remains one of the important tasks we face. We are exploring a number of options, including membership dues, debt financ-

INDEPENDENT PRACTICE ASSOCIATION

ing from banks, and other possibilities. Financing and legal structural issues are intertwined, and we are carefully considering the consequences of this important decision.

Many timely strategic operation decisions are required of us to complete IPA development within six to twelve months. We have established a steering committee to act on behalf of the full Ad Hoc IPA Committee as necessary and to monitor the process of development.

After discussions with more than ten legal firms and interviews with more than five, the steering committee selected the law firm of Sidley & Austin of Washington, DC, to provide legal guidance to us in this matter. The law firm has offices in New York, Los Angeles, Washington, DC, and Chicago, and has been selected by the AMA to act on its behalf in matters concerning IPAs, etc. The firm prepared a paper for the AMA entitled "Representing Physicians in an Era of Change: The Role of State Medical Societies Under Managed Care and Health Reform." A letter of engagement was signed on July 11, 1994, and David Ford, Esq., has begun work on developing the articles of incorporation and bylaws for a non-stock, non-profit entity.

The new corporation would be governed by an eleven-member board of directors initially selected by the Med Chi board of trustees.

The day-to-day operations of the corporation would be controlled by a five-member executive committee consisting of the principal officers of the corporation.

The corporation would be established to: (1) pursue the creation of a statewide physician network that may offer physician services to a multitude of managed care providers or other third-party payers; (2) develop and implement innovative, "physician-friendly" programs for credentialing, quality assurance, utilization review, focused professional education, peer review, cost containment, etc., which may be offered in conjunction with the statewide physician network or as an independent product to managed care providers; and (3) engage in other managed care activities consistent with the interests of the Med Chi membership.

Even with the creation of extensive panels and the availability of financing, the final success of this Med Chi-sponsored endeavor will depend on successful marketing and contract negotiations. We are already in informal negotiations with one of Maryland's major insurers to market our proposed IPA as a part of one of their offerings.

We continue to believe that a Med Chi-sponsored statewide organization will successfully represent the interests of physicians in the marketplace of the future. But this is a complex, lengthy process, and we plan to move deliberately and cautiously. We will keep you informed of our progress and continue to welcome your input, recommendations, and questions.

AD HOC IPA COMMITTEE MEMBERS (*Denotes member of the steering committee)

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Preliminary Program

1994 Semiannual Meeting of the Medical and Chirurgical Faculty of Maryland

Friday, September 9 -
Sunday, September 11, 1994

Sheraton Ocean City Resort and Conference Center

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education (CME) activity for up to 11.5 hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Physicians attending this year's meeting can earn up to a maximum of 7.5 CME credits.

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VISIT THE EXHIBITS

Exhibits are an integral part of the Med Chi Semiannual Meeting and are a valuable adjunct to the scientific program.

During this year's semiannual meeting, Med Chi has allocated several special time periods for physicians to meet one-to-one with exhibitors. By visiting exhibits, you will help ensure that Med Chi continues to receive valuable income that allows us to offer these annual and semiannual meetings.

**VISIT THE
EXHIBITS
BETWEEN
12:00 noon
AND 7:00 p.m.
ON FRIDAY**

Med Chi urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.

**Please note:
Exhibits will be open
Friday and Saturday
only!**

FRIDAY, SEPTEMBER 9



12:00 p.m. - 6:00 p.m. **Registration open**

12:00 p.m. - 7:00 p.m. **Exhibits open**

1:30 p.m. - 2:00 p.m. **House of Delegates Registration**
All delegates and alternate delegates must register during this time and be seated by 2:00 p.m. when the meeting begins.

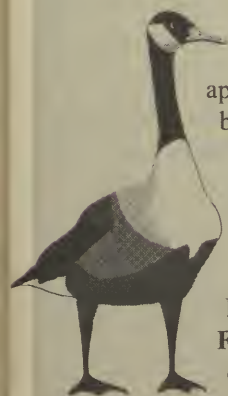
2:00 p.m. - 5:00 p.m. **House of Delegates Meeting**
Speakers: W. Aubrey Godfrey, M.D., Medicare Medical Director, Blue CrossBlue Shield
Dennis Carroll, Associate Regional Administrator for Medicare, Health Financing Administration, Region III

5:00 p.m. - 6:00 p.m. **Committee on Scientific Activity**
Marcus Welby, M.D., vs. the Marlboro Man: Progress Toward a Tobacco-Free Society

Speaker: Ronald M. Davis, M.D., Chief Medical Officer, Michigan Department of Public Health
Objective: Participating physicians will be aware of the status and history of the smoking issues in the limelight today, including trends in use, the stance taken by public health organizations, the value of legislative/excise tax initiatives, medical knowledge about addiction, and the impact of physicians on the tobacco control movement.

Target audience: All physicians
CME credits: 1.0

6:00 p.m. - 7:00 p.m. **Welcome Reception — Exhibits open**
All physicians, spouses, and exhibitors welcome — Compliments of Sheraton Ocean City and Dr. Leonard Berger



KEYNOTE SPEAKER

Nancy W. Dickey, M.D.
*Vice-Chairperson, Board of
Trustees, American Medical
Association*

Nancy W. Dickey, M.D., a board certified family physician from Richmond, Texas, served as secretary-treasurer of the AMA from 1993 to 1994, and has been a member of the Board's Executive Committee since 1991. Dr. Dickey chairs the AMA's Ad Hoc Technical Advisory Committee on Health System Reform. She has served as an AMA commissioner for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) since 1989, including service on the Accreditation Committee, the Standards-Survey Procedures Committee and the Task Force for Psychiatric Facilities. She chaired the Finance Committee from 1992 to 1994 and served as a member of the Board's Subcommittee on Membership from 1993 to 1994.

A graduate of the Stephen F. Austin State University, she received her medical training at the University of Texas Medical School at Houston, where she was a recipient of the Distinguished Alumni Award. She is currently associate professor, family practice and community medicine at the University of Texas Medical School in Houston. She has served as a reviewer for the *Journal of the American Medical Association* and on the editorial advisory boards of *Patient Care*, and *Medical World News*. She currently serves on the editorial board of *Medical Ethics Advisor*.



VISIT THE EXHIBITS BETWEEN 7:30 a.m. AND 4:30 p.m. ON SATURDAY

Saturday, September 10

7:00 a.m. - 9:00 a.m.

*Committee on Scientific Activity and Medical
Mutual Liability Insurance Society of
Maryland (Med Mutual)*

Trials and Deliberations in Medicine

(Medical Mutual members who attend this session are eligible for a 5% premium discount on their 1995 medical professional liability renewal policy. A \$40 program fee is required for this discount.)

Speakers: Daniel E. Kohn, M.D., F.A.C.E.P., President, Maryland Chapter, A.C.E.P.

Elizabeth Svoisky, B.A., J.D., Assistant Director, Risk Management Services, Medical Mutual/Mid-Atlantic

Wayne Zack, B.S., Claims Supervisor, Medical Mutual

Objectives: Participating physicians will be able to identify current patient care issues, have an increased knowledge of medical diagnostic and treatment options, be able to describe the legal process, from service of suit through trial, and be able to discuss the application of risk management recommendations.

Target audience: All physicians

CME Credits: 2

7:30 a.m. - 8:30 a.m.

Continental Breakfast in the Exhibit Hall

7:30 a.m. - 4:30 p.m.

Registration and Exhibits open

9:00 a.m. - 12:00 noon

Reference Committee Meetings

12:00 noon - 1:00 p.m.

Lunch on your own

1:00 p.m. - 2:00 p.m.

Committee on Scientific Activity

KEYNOTE ADDRESS — National Health System Reform: from The Health Security Act to the Patient Protection Act

Speaker: Nancy Dickey, M.D., Vice-Chairperson, Board of Trustees, American Medical Association

Objectives: Participating physicians will gain a better understanding of the status of various national health system reform plans, the status of the Patient Protection Act, and the potential outcomes of the health system reform debate in Congress.

Target audience: All physicians

CME credits: 1.0

2:00 p.m. - 3:00 p.m.

Break — Visit the Exhibits

3:00 p.m. - 5:30 p.m.

Committee on Scientific Activity

Parliamentary Procedure

Speaker: James Davis, M.D., Past President, American Medical Association; Former Speaker, House of Delegates

Objectives: Participating physicians will understand the basic rules of parliamentary procedure, know rules governing motions and requests, and receive advice on conducting meetings.

Target audience: All physician leaders

CME credits: 2

Note: there will be a break from 4:00 p.m. to 4:30 p.m. during this session.

3:00 p.m. - 4:00 p.m. *Committee on Scientific Activity*

Health Care Rationing and Physician Ethics

Speaker: M. Roy Schwarz, M.D., Senior Vice President for Medical Education and Science, American Medical Association

Objectives: Participating physicians will gain a better understanding of the status of and potential for health care rationing and become more aware of the ethical problems physician face under rationing.

Target audience: All physicians

CME credits: 1.0

4:00 p.m. - 4:30 p.m. **Break — Visit the Exhibits**

4:30 p.m. - 6:00 p.m. *Committee on Scientific Activity*

The Use and Abuse of RBRVS

Speaker: J. Leonard Lichtenfeld, M.D., Secretary/Treasurer of the American Society of Internal Medicine

Objectives: Participating physicians will be able to describe RBRVS, be aware of the current issues surrounding RBRVS, and understand the misuse of RBRVS in the Medicare and non-Medicare payment systems.

Target Audience: All physicians

CME Credits: 1.5

4:30 p.m. - 5:30 p.m. *Committee on Scientific Activity*

Preventing the Complications of Diabetes: An Interactive Approach

Speaker: Joseph W. Zebley, M.D., Past President, Maryland Academy of Family Practice

Objectives: Participating physicians will be able to cite data on the burden of diabetes in Maryland, discuss the results of the Diabetes Control and Complications Trial, understand the positive impact of increased patient involvement on the control of blood glucose levels, and use the *Diabetes Handbook* (a physician-patient diabetes reminder system) with their patients to improve care and reduce the complications of diabetes.

Target audience: Primary care physicians

CME credits: 1.0

Sunday, September 11     

8:00 a.m. **Continental Breakfast**

8:00 a.m. - 12:00 noon **Registration open (no exhibits)**

8:30 a.m. - 9:30 a.m. *Committee on Scientific Activity*

HIV: New and Experimental Treatments and Opportunistic Diseases that Attack HIV Patients

Speaker: Nancy Ruiz, M.D., Specialist in Infectious Diseases, Henry M. Jackson Foundation for the Advancement of Military Medicine at the Bethesda Naval Hospital

Objectives: Participating physicians will be aware of the new and experimental treatments for HIV patients and be better prepared to recognize the opportunistic diseases which frequently attack HIV patients.

Target audience: All physicians

CME credits: 1.0

HOTEL INFORMATION

The Sheraton Ocean City Resort and Conference

Center is located at 10100 Ocean Highway. Med Chi has reserved a block of rooms at a special

group rate of \$114 per night, single or double occupancy (tax and incidentals not included). To reserve your room, call 1-800-638-2100 and tell them you'll be attending the Med Chi semiannual meeting. Please reserve early — reservation deadline is August 25, 1994 — but rooms may fill prior to this date.

Check-in time at the Sheraton is 3:00 p.m. **Guests will not be able to check into their rooms prior to 3:00 p.m. on their arrival date.** Check-out time is 11:00 a.m.

DIRECTIONS TO THE SHERATON

The Sheraton Ocean City Resort and Conference Center is located at 10100 Ocean Highway. The map below shows how to get there from the surrounding areas.



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8:30 a.m. - 9:30 a.m. *Committee on Physician Rehabilitation*

Informing the Patient about the Diagnosis of Addiction Including When the Patient is a Physician

Speaker: Frank L. Iber, M.D., Professor of Medicine, Loyola University, Stritch College of Medicine, Hines, Illinois

Objectives: Participating physicians will ➤ explore strategies for informing patients of the diagnosis of substance abuse, ➤ learn methods of relating the diagnosis to the patient that may increase the patient's motivation to follow up with treatment, and ➤ identify and explore various motivational techniques that will increase their success when referring alcoholic or chemically dependent patients.

Target audience: All physicians

CME credits: 1.0

9:30 a.m. - 10:00 a.m. **House of Delegates Registration**

All delegates and alternate delegates must register during this time and be seated by 10:00 a.m. when the meeting begins.

10:00 a.m. - 12:00 noon **House of Delegates Meeting**

12:00 noon **Adjournment**

1994 Semiannual Meeting Registration Form

Medical and Chirurgical Faculty of Maryland

Friday - Sunday, September 9 - 11, 1994

Sheraton Ocean City Resort and Conference Center

Check one: ☐ Med Chi member - no charge
☐ Preregistered nonmember - \$35.00 (includes all CME presentations)

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Please return this form (and check made payable to "Med Chi" if a nonmember) to:

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1211 Cathedral Street
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For additional information, call Heather Johnson, Vivian Smith, or Ruth Seaby at 410-539-0872 from the Baltimore area or 1-800-492-1056 from elsewhere in Maryland.

Physician education

John W. Buckley, M.D.

Dr. Buckley is editor of the *Maryland Medical Journal*.

"MEDICAL EDUCATION BEGINS FORMALLY WHEN THE PROSPECTIVE PHYSICIAN enters college to prepare himself for admission to medical school and ends only when he dies or permanently retires."¹ As the medical profession faces health system reform, changes driven by market forces, and technological advances, educators, physicians, and even politicians have begun to examine the current medical education system. Therefore, this issue of the *Maryland Medical Journal* is dedicated to medical education, the role it plays in our profession, and its future direction.

Ascribing to the principle that we cannot know where we are going unless we know where we have been, the first article in this issue, by Perry Hookman, M.D., F.A.C.P., F.A.G.G., provides a historical perspective on the theories that helped shape the curriculum and the faculty appointments of most contemporary medical schools. Dr. Hookman's article highlights the differences between Franklin Paine Mall, who believed medical training should focus on the causes of diseases, and Sir William Osler, who believe that medical education should "place major emphasis on teaching students the techniques and skills necessary for observing and interpreting the manifestation of disease in patients and less on the investigation of the underlying cause of the disease process."

Theodore E. Woodward, M.D., M.A.C.P., in his article "A physician is first a good physician: A proposal for training in primary care," gives his view of the current inadequacies in physician training and offers a paradigm for restructuring medical training.

Dr. Woodward's article is followed by commentaries on medical education from the deans of Maryland's medical schools. Nancy E. Gary, M.D., M.A.C.P., dean of the Uniformed Services University of the Health Sciences F. Edward Hébert School of Medicine, proposes ten events for reshaping physician education for the second millennium. Michael M. E. Johns, M.D., dean of The Johns Hopkins University School of Medicine, speaks of the "new generalists" in the medical profession and how Hopkins is designing the curricula of its medical school and continuing medical education programs to help physicians face the professional challenges created by health system reform, market forces, and technological advances. Donald E. Wilson, M.D., M.A.C.P., dean of the University of Maryland School of Medicine, explains why the traditional methods of education no longer adequately prepare students for the practice of medicine. Dr. Wilson advocates developing "a curriculum that will emphasize equipping students with the motivation and ability to engage in a lifetime of learning."

Continuing medical education is one way practicing physicians "engage in a lifetime of learning." During the most recent meeting of its House of Delegates in June, the AMA reaffirmed and expanded its support of continuing medical education as central to the provision of patient care of the highest possible quality. The three articles following the deans' commentaries address continuing medical education. John B. DeHoff, M.D., staff medical consultant of the Board of Physician Quality Assurance, gives an overview of the CME requirements for renewal or reinstatement of a Maryland medical license.

Dr. DeHoff's article also explains the difference between Category 1 and Category 2 CME credits and how each type can be obtained. The next article, by Deusdedit Jolbitado, M.D., member of the Committee on Continuing Medical Education Review, explains the process used to accredit CME programs. The final article on continuing medical education, by Edward J. Kowalewski, M.D., and Cora H. Teter, M.S., gives an overview of the Focused Professional Education program administered through Med Chi's Committee on Focused Professional Education. The articles on medical education conclude with a Vignette of Medical History by Joseph M. Miller, M.D., on the first women's medical college in the United States.

How physicians are educated and how that educational process is perceived by our patients has a profound effect on the way we practice medicine. As editor, I want to thank each of the authors for their contributions on a subject of great importance to all physicians.

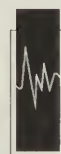
Reference

1. Weiskotten HG. Responsibility of a profession for the promotion of educational standards. In: Proceedings from the 46th Annual Congress on Medical Education and Licensure; Chicago, Ill; 1950:5. ■

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Donald Kirson... "Well, home medical companies provide service, but don't have the overhead that a hospital or a long term care facility would have."

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Sir William Osler and the current trajectory of medical education and health care at American academic health centers

Perry Hookman, M.D., F.A.C.P., F.A.C.G.

*Dr. Hookman is a
Washington, DC, consultant.*

At the end of the nineteenth century, prominent medical educators put academic health centers on a trajectory that shifted the focus of clinical education from primary care to basic science research and encouraged the employment of full-time research faculty rather than part-time instructors with private practices. By weakening the ties between teaching and private practice in the community, this thrust has led to concerns about the focus of medical education. This article examines how the changes occurred at The Johns Hopkins University School of Medicine, one of the first institutions to adopt the new focus. It highlights the disagreements about medical education among leading Maryland physicians of the late nineteenth and early twentieth centuries. It also analyzes the implications of maintaining an educational hierarchy driven by research grants.

Franklin Paine Mall

One of the major proponents of changing medical education was Franklin Paine Mall, a distinguished scientist and perhaps the greatest anatomist of his time.¹ In 1893, he began a 28-year fight to reorient the second two years of clinical medical education at The Johns Hopkins University School of Medicine. Encouraged by new scientific findings about vitamins, pathogenic bacteria and their relation to infectious diseases, and the mechanism of internal secretion, Mall pushed for medical training that emphasized the search for causes of diseases rather than their patterns.

In 1904, Mall explained his view of how medical education should be reformed to respond to the impact of new scientific discoveries. He wanted to introduce changes favoring students who are inclined to become scientific physicians and steadfastly advocated employing teachers who are investigators. He warned: "If a physician is educated only in the sciences underlying medicine he is not a physician.... If he is educated in the practical branches alone he is likely to become a shoemaker-physician who will drift into ruts and never get out of them."² Mall concluded that the difference between a shoemaker-physician and a scientific physician "is that the theories of the former rest upon a small collection of individual observations and a chaotic

mass of reminiscences, while those of [the] latter rest upon the scientific investigations and experience of many minds during many centuries."²

Mall proclaimed that research should be placed above teaching and science above medicine. He viewed clinical medicine without research as a mere trade and practicing physicians as mere tradesmen: "An educational institution of highest order must carry on perpetual warfare against drilling trades into inferior students, in order to retain its high position. And, above all, the medical profession should be filled with learned men, and not tradesmen, in order to be of the greatest good to the community."³

As a result of his desire to keep science separate from commerce and to educate scientists rather than tradesmen, Mall strongly opposed the money-making activities of the clinical faculty at Hopkins:

The problem would be easy if the pork barrel were removed. . . . Remove the exploiting medical professor and open the way for a real university professor of medicine. We are told that medical and surgical professors cannot take interest in medical problems and the sick unless they are paid for each move. . . . It falls to us to demand of the last two years of medicine what they demanded of the first two and I think that the day of reckoning is at hand.²

Sir William Osler

One hundred years following the publication of Sir William Osler's seminal medical text, *Principles and Practice of Medicine*, it might be assumed that Osler supported the changes advocated by Mall. His response, however, was vehement, adamant, persistent opposition.

Osler, a trained pathologist, was known as "a master of observation and description of disease as well as a great diagnostician."³ His views were not due to lack of appreciation of the rapid advances in physiology and chemistry and the consequences of these major discoveries for clinical medicine. Indeed, the ever-increasing application of science to medicine left Osler unshaken in his conviction that medicine itself must remain an art, and distinctively the art of establishing rapport between the physician and the patient. He believed that a person who stood aside from the process of humanizing and being humanized by the friction of personal context might be a scientist, but never a doctor.⁴

For Osler, this humanizing relationship also extended to educational methods. Unlike Mall, Osler "placed major emphasis on teaching students the techniques and skills necessary for observing and interpreting the manifestation of disease in patients and less on the investigation of the underlying disease processes."³ Osler feared Mall as the very image of the "full-time man."⁴ He disliked Mall's "inductive method" of teaching anatomy and deplored Mall's remoteness from his students:

"The teacher who wraps himself in the cloak of his researches and lives apart from the bright spirits of the coming generation misses the greatest zest in life...."⁴

Also unlike Mall, Osler found private practice to be extremely valuable to his educational technique and defended the practice of collecting fees from patients. He later wrote:

On the question of private practice and of fees I can speak freely to the enormous value of the outside work in one's personal and professional development.... In looking over my writings for this specific purpose I am surprised to see how much of my very best material came from this source.⁵

The demise of part-time faculty

When he arrived at Hopkins in 1893, Mall was convinced that full-time faculty members should replace those who had outside practices. He also may have reached a quiet understanding with William H. Welch, then chairperson of the department of pathology and later dean of the medical school. Welch, a full-time academic whose ideas were similar to Mall's, apparently promised Mall some financial resources to support changes in medical education "which will not appeal to the mass of the public, not even to the medical public, for a considerable time."²

Osler and most of the other part-time faculty consistently opposed Mall's plans throughout the last decade of the 1800s and the early 1900s. Osler believed that teaching by full-time, research-oriented faculty probably would produce "a set of clinical prigs, the boundary of whose horizon would be the laboratory and whose only human interest would be research."⁴ In time, however, Osler came to believe in the inevitable success of Mall's long-planned and well-calculated campaign to oust permanently from Hopkins medical school part-time faculty or professors with outside private practices.

Perhaps because of this, Osler left Hopkins in 1905 for the Regius Chair at Oxford. But such was Osler's reach that it took two more years for Mall to convince Welch that the time had come for the part-time heads of the principal clinical departments—particularly medicine, surgery, pediatrics, and psychiatry—to devote their full time to teaching and investigation. Even with Welch in agreement, persistent opposition from Osler's followers made it difficult to implement these plans. In fact, implementation did not occur for another six years, after additional impetus from Abraham Flexner's influential 1910 study, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation*,⁶ and after the additional incentive of a grant from the general education board of the Rockefeller Foundation.

Flexner, who counted Mall and Welch as his good friends, thought that Hopkins, even with part-time faculty, was one of the top medical schools in the country. He nevertheless maintained that the ideal school for teaching medical students

was one with full-time faculty members who did not have private practices. This view also was advocated by the Rockefeller Foundation.

By 1911, even while in England, Osler was concerned about Flexner's influence. Counterattacking Flexner's statement that "part time faculty were preventing the more complete development of the [Johns Hopkins] schools," Osler cited "500 contributions to scientific medicine from the graduates of the first eight years of Hopkins which were more brilliant from the clinical side than from the laboratory side."⁵ Osler also cautioned: "Men whose main interest was the research aspect of medicine and who...were out of touch with the rank and file of the medical profession could not train students for the practice of medicine of which they know nothing and

care less.... Do not be led away by the opinions of the pure laboratory men who have no knowledge of the clinical situation or its needs."⁵

Despite Osler's protestations and objections from part-time faculty, in 1913, Hopkins told the general education board of the Rockefeller Foundation that it would begin hiring full-time clinical chiefs. To receive the foundation's gift of \$1.5 million (about \$12 million in 1993 dollars), Hopkins administrators were required to make the clinical department chiefs' positions into full-time jobs. Professor of medicine Llewellys F. Barker, who originally had been enthusiastic about the full-time concept, resigned rather than give up his private practice; Theodore C. Janeway became the first full-time professor of medicine. John Howlands became the first full-time clinical professor of

Commentary

Dr. Hookman correctly points out that the educational mission of academic medicine is threatened. This is especially true in the era of health care reform and shrinking support for research. As medical schools attempt to address changes in clinical care so that they can sustain an income stream that subsidizes their academic mission and as they work to become more competitive in obtaining research monies, their educational mission is in danger of becoming lost in the shuffle.

The department of medicine at The Johns Hopkins University School of Medicine has a legacy of counting among its faculty outstanding teachers and clinicians; Osler, Longcope, Tumulty, to name a few. In order to send the message that education is still important and central to its mission, the department of medicine decided several years ago to use some of its endowment to support outstanding teachers and role models; individuals who, in the process of taking care of patients, teach medical students and house officers the art as well as the science of medicine. To date, two endowed chairs—the Mary Betty Stevens Chair and the David Carver Chair—have been given to such individuals (David Hellmann and Stephen Achuff, respectively).

In order to affirm its commitment to support teaching, the department of medicine at Johns Hopkins wishes to establish endowments to support our most gifted and innovative teachers so that they can devote more of their time to teaching. The endowments will be under the programmatic theme of "Osler scholars." Individual endowments could bear the name of the donor or their designee. These endowments will send the strong message that contributions in the classroom are as important as those in the laboratory. The program has the following features:

- ❑ Interest on the endowment will be used by the faculty member for salary support. This support should replace support derived from other sources (e.g., clinical practice) and therefore allow the faculty member to devote more time to teaching. This time could be used in a variety of endeavors, such as developing more effective teaching methods or spending more time teaching. The goal of the Osler support is to enhance the teaching component of the recipient's effort. At least one-half of the endowments will be used to support individuals who are recognized as outstanding teachers of general internal medicine.
- ❑ All department of medicine faculty, including part-time faculty, will be eligible.
- ❑ Candidates will be determined by a selection of oversight committee appointed by the chairperson of the department of medicine and the dean of the medical school. Candidates will be selected from a pool of clinical scholars (i.e., faculty who provide clinical care and are excellent role models and teachers).
- ❑ The award will be given for an initial period of five years with competitive renewal available for another five years, as determined by the oversight committee.

Interest in the program has been high. Most important, it has rallied faculty and particularly alumni to our commitment to education and will provide tangible support for this, our most basic mission.

JOHN D. STOBO, M.D.

Dr. Stobo is William Osler professor of medicine at The Johns Hopkins University School of Medicine. ■

pediatrics, William S. Halsted the first full-time professor of surgery, and Adolf Meyer the first full-time professor of psychiatry. Although all had excellent clinical experience, none was allowed a private practice.

From that point on, the trajectory of American health care—as construed at prominent academic health centers like Hopkins—was programmed and launched. A choice had been made between the points of view epitomized by two men who “represented two different types of medicine, [Osler] the type that stresses the humanities, develops in full the powers of observation and the art of dealing with the sick, and [Mall] the type of scientist who strives toward the understanding of disease.”²

Second thoughts

Although full-time faculty members were in charge of all key areas of clinical training by 1913, conflicts about the role of research in clinical training and the hiring of full-time faculty continued, in part in response to Osler’s strong objections. Such was Osler’s prestige that, after Osler’s death, Welch tried to alter public perceptions of Osler’s beliefs.

When Welch read Harvey Cushing’s *The Life of Sir William Osler*, which discussed Osler’s objections to full-time faculty, Welch wrote a review of the book in which he attributed many of Osler’s objections to Cushing, emphasized Osler’s own reservations about opposing full-time faculty, and otherwise sought to diminish Osler’s views.⁷ Concerned that opinion might turn and that the Rockefeller Foundation might alter the grant, Welch had 2,000 copies of his review printed and circulated to influential physicians and key medical decision-makers, including members of the foundation.

Despite Welch’s attempts to ensure that prominent medical educators embraced his beliefs, he also ultimately developed reservations about the system he had originally advocated. In 1926, he wrote, “The development of these newer fields and methods of clinical research is assuredly to be welcomed as an important part of the progress of scientific medicine, but it is pertinent to inquire whether the new order will develop clinicians with the breadth of interest in all kinds of disease characteristics of the best of the older generation of clinicians, exemplified by Osler, the scientific basis of whose work was pathology and the analysis of accumulated clinical data.”⁷

Mall also began to develop reservations about the basic research and disease etiology orientation he had worked so hard to develop as the keystone of clinical training. As he wrote later in life: “Medical research must pass from the study of disease to that of health. The lesson of the nineteenth century, the greatest lesson of that century, is that the object of medical study is for the maintenance of health rather than the cure of disease.”²

Despite their own subsequent reservations, however, Welch, Mall, and their supporters successfully established

“full-time research as a central function of clinical faculty at the best institutions.... Research was plainly established not only as a significant expectation of faculty, but as a crucial element of the milieu in which students were educated, and in fact, enculturated.”⁸

Results by mid-century

This educational model, in which clinical faculty focused on research while trying to maintain a commitment to patient care, was accepted and used through the mid-1940s. After World War II, however, the Federal government began funneling ever-increasing amounts of funds into basic and clinical research. As a result, “scholarliness came to be progressively, and ultimately nearly exclusively, identified with basic and clinical research, and research productivity became, in most schools, the high road, usually the only road to the tenure-track academic career.”⁸ Private practitioners were virtually excluded from the tenured faculty track. Dependent on patients rather than research grants for their financial survival, they were more concerned with clinical care than conducting research. Their disappearance from faculty sacrificed much of patient-oriented clinical care in favor of research-oriented care.

As Osler predicted, the primacy given to research also profoundly altered both the content and priorities of medical teaching. The nature and characteristics of disease predominate and “teaching, even on the clinical level, has become more and more fragmented as physiologic, cellular, and molecular events are presented by specialists-investigators in the relevant fields of inquiry.”⁸ Teaching priorities in the clinical departments have been reorganized, “with training of fellows at the head of the list; education of house staff, second; and teaching of medical students, last.”⁸

A new “Oslerism”

In response to the growing emphasis on research rather than patient care, a movement towards a “new Oslerism” began in the 1950s. While acknowledging the importance of basic research, reformers objected to the concomitant diminution of clinical care and suggested that Mall and Welch would have agreed with Osler and opposed the changes in medical education if they could have foreseen the results of their efforts.² Oslerian reformers believed that medical arts, especially medical ethics, were best learned in clinical settings, not laboratories, and urged members of the “medical professions ... to turn again to the bedside.”⁹

In the 1960s, the General Professional Education of Physicians (GPEP) undertook a comprehensive review of clinical education and proposed a broad range of changes to improve humanism in medicine. In the 1970s and 1980s, calls for reform continued. In 1978, Regelson¹⁰ stated that the quality of medical care delivered by practicing physicians was related

directly to the quality of the student-teacher relationship in medical school. Contemporary medical education was inadequate, he continued, because there was little commitment to the "teachings of medicine as a healing art." Maintaining that the "new academic breed" was too busy procuring federal research grants and improving their record of publications to keep up with students' needs and patients' demands, he advocated the return of "the Oslerian broad-based academic humanist with his emphasis on empathy, patient care and teaching."

By the mid-1980s, reformers increasingly questioned whether academicians had taken Flexner's recommendations too far. Contributors to the *Journal of the American Medical Association* who addressed the issue of clinical education in academic medical centers and authors published in the *Journal of American Medical Education* agreed that new emphasis on the traditional art of medicine was necessary.¹¹

Today, some changes are being made. Most notably, new "clinician-teacher" tenure tracks are being developed.¹² However, much of medical education remains enamored of research and relies on research funding for critical support. In such an environment, part-time faculty have much more difficulty being promoted, in contrast to full-time faculty active in research.

This was true at Hopkins until John D. Stobo, the school's current William Osler Professor of Medicine, recently established the Osler Scholar Program for endowments to support the "most gifted and innovative teachers" so that they can devote more of their time to teaching. This financial support would replace other sources, such as research grants, and allow faculty members to spend more time with students.


Perhaps a solution also was foreseen by Osler who, in 1905, adjured medical educators to:

Remember what we do today the other schools will try to do tomorrow. . . . But, lastly and chiefly, divert the ardent laboratory souls who wish to be whole-time clinical professors away from the medical school in which they are not at home to the research institutes to which they properly belong, and in which they can do their best work.¹³

References

1. Fleming D. *William H. Welch and the Rise of Modern Medicine*. Boston, MA: Little. 1954.
2. Sabin FR. *Franklin Paine Mall: The Story of a Mind*. Baltimore, MD: Johns Hopkins Press. 1934.
3. Harvey AM, McKusick VA, Stobo JD. *Osler's Legacy: The Department of Medicine at Johns Hopkins 1889-1989*. Baltimore, MD: Johns Hopkins Press. 1990.
4. Fleming D. The full time controversy. *Johns Hopkins Alumni Magazine* 1954;6:11,32.

5. Letter from William Osler to Ira Remsen. *Can Med Assoc J* 1962;87:762-64.
6. Flexner A. *Medical Education in the United States and Canada*. New York, NY: The Carnegie Foundation for the Advancement of Science. 1910.
7. Welch WH. Physician and humanist. *Saturday Review of Literature* 2:309-10, 21 November 1925.
8. Barondess JA. The academic health center and the public agenda: Whose three-legged stool? *Ann Intern Med* 1991;115:962-67.
9. Carawasha WR. Technical zeal or therapeutic purpose: How to decide? *JAMA* 1983;250:1857-59.
10. Regelson W. The weakening of the Oslerian tradition. *JAMA* 1978;239:317-19.
11. Vinten-Johansen P. New Oslerians and real Flexnerians: The response to threatened professional autonomy. *Int J Health Serv* 1991;21:75-108.
12. Levinson W, Kaufman K, Bickel J. Part-time faculty in academic medicine: Present status and future challenges. *Ann Intern Med* 1993;119:220-225.
13. Osler W. William Osler's farewell address to American and Canadian medical students. *Can Med Assoc J* 1962;67:762-64.




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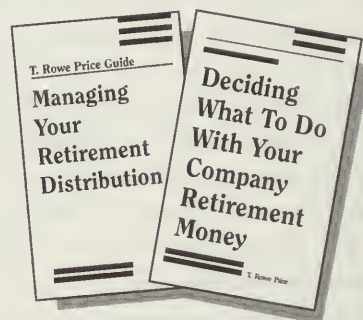
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A physician is first a good physician: A proposal for training in primary care

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Over two decades ago, it became increasingly apparent that technological advances and changing interests were altering traditional approaches to medical care delivery. The personalized doctor-patient relationship gradually gave ground to specialized care from the various traditional fields of internal medicine (cardiology, gastroenterology, endocrinology, rheumatology, hematology-oncology, pulmonary and infectious diseases, nephrology). Although contributions from these subspecialties unquestionably have advanced medical knowledge to a level never before thought possible, a key element is lacking: balance between delivery of comprehensive care and use of the highest possible technological advancements.

Generalists and specialists

In a recent group discussion, a junior medical student presented the following patient information:

A 66-year-old man visited the clinic for follow-up examination. Although his abdominal girth was full, he appeared physiologically quite old and there was general muscular wasting. He had recently lost 20 to 25 pounds. He had mild shortness of breath and nagging upper abdominal pain. Five years earlier, abdominal surgery had confirmed a diagnosis of carcinoma involving the intestinal tract. Hospitalization was recommended. The patient had normal bowel movements; stool showed no occult blood. There was a 1.5 cm firm lymph node in the left axilla; a recently developed, firm-to-hard, walnut-sized nodule anterior to the upper sternum; and scattered rhonchi. The liver was twice normal size, filling over half the abdominal cavity, and was very hard on palpation. In addition to liver biopsy (results of which showed adenocarcinoma), the patient underwent a complete hematologic profile, computed tomography (CT) examination of the chest and abdomen, and colonoscopy. There were two separate specialty consultations.

The medical student who described the case wondered "why so many things were done." Indeed, how can we condone such management of a patient whose admitting diagnosis, confirmed five years previously, was

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metastatic cancer? Would it not have been wiser for the physicians in charge to have asked themselves if the hospitalization or procedures were necessary to formulate a comprehensive management schedule best suited for the patient? If there was a strong need to verify a confirmed diagnosis, why not do a biopsy of the accessible external nodule under local anesthesia while the patient was in the outpatient clinic? This would have avoided 14 days of hospitalization and an unnecessary, expensive medical survey. Would it not have been reasonable to discuss the situation with the patient and his family, and then make the best and most humane decision? Are we so academically minded that we abandon common courtesies, which are all the public expects in such medical situations?

Training as a primary care internist is really training to be a physician who cares for the total patient, whether the problem is organic or emotional. Germane to all clinical problems is the ability to thoroughly evaluate the medical history, perform an accurate physical examination, and analyze technological data. Although primary care internists in metropolitan centers or large community hospitals are more prone to refer patients to readily available specialists, this practice is unwarranted in most situations. Under ordinary circumstances, myocardial infarction, acute lung or other infections, complicated diabetes, renal failure, and shock do not require supervision or direction by specialists. Primary care physicians should be able to differentiate between a routine

problem and a complicated condition, referring the patient to a qualified specialist only after their own evaluation has been thorough.

Another recent experience reinforced my views. Three consulting specialists rendered advice on the care of a very ill patient with serious complications following a major surgical procedure. One devoted attention solely to an arrhythmia, another to whether the pulmonary problem was acute respiratory distress or pulmonary edema from congestive heart failure, and the third to the choice of antibiotics. None, however, specifically addressed the underlying, uncontrolled intra-abdominal infection that required drainage and caused the patient's desperate condition.

In my opinion, American medical schools and teaching hospitals must adopt the attitude that a physician is first a physician who cares for patients and their problems; the common connecting link between a generalist and specialist should be broad competence and dedication to patient welfare. Proper training with day-to-day patient experiences, under guidance, is a proven system that provides an effective setting for achieving this competence. With careful planning and by coordinating teaching and application of basic principles during the pre-clinical and clinical training phases, the desired competence can be achieved. Any medical educational system that fails to accept and inculcate this concept in its teaching will not reach top rank.

Commentary

Have we neglected basic principles inherent in the practice of medicine and in the education of physicians? Do we encourage physicians through our education process to understand that our first obligation is to care for patients—to care in the sense of being responsible for the welfare of a person, rather than a disease or a piece of technology?

Patients expect physicians to possess a comprehensive body of scientific knowledge and to relate to them in a humanistic manner that reflects concern for the welfare of each individual patient. Of question is whether current educational policy results in the education of physicians who are devoted to both scientific and humanistic excellence. Who, besides the physician, can be expected to have a global understanding of the scientific, clinical, financial, social, and emotional aspects of illness? It is serious business to be a physician. How comprehensive should medical education be?

Medical students are no longer attracted in the same numbers to a career in general internal medicine. The

intellectual stimulus provided by this discipline has been tarnished by a number of factors, not the least of which, as Dr. Woodward illustrates, is the education process itself.

Dr. Woodward proposes a return to more comprehensive and broad-based education of medical students and physicians beginning postgraduate training. He advocates a "liberal arts" form of training for all physicians before special interests are developed. He encourages a closer working relationship between generalists and specialists. Above all, he stresses the seriousness and importance of combining basic theory with clinical practice.

Dr. Woodward's views are founded on years of experience and a careful analysis of the educational process. It is time to reexamine our educational goals; Dr. Woodward's paper is a good start.

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Inadequacies in physician training

Selection of medical students. Today's college students strive for high grades, but often are less broadly educated and have fewer cultural interests or attainments than students from earlier generations. In many cases, there is less interest in cultural pursuits and limited participation in college activities because of concerns that the grade point average might suffer.

A prominent college educator once spoke to me of a gifted science student. The advisor wondered whether the student should study *Gray's Anatomy* and a medical text during his senior year. My suggestion—that the student take more courses in literature, learn to speak English well, become proficient in another language, and enrich his cultural growth through study of the classics—was surprising to him. I believe the current medical school selection process needs considerable revision and greater emphasis on cultural attainments and character traits.

Core curriculum. Recent changes in medical school curricula are partially responsible for knowledge gaps. The changes began with the concept that in the undergraduate years a limited, "core" curriculum is sufficient. As a result, most medical students are no longer schooled in the performance of physiologic or dynamic experiments. Instead, they attend lectures, often filled with endless details, without any discussion of broad concepts. They do not participate in chemical analyses or laboratory procedures. They may perform a white blood cell count or two, but never a spinal fluid count and few, if any, smears of stools, urine, exudates, or blood. No longer is a normal or fibrillating heart observed, a coronary artery ligated in an animal and later released at varying periods, an intestinal loop seen to exude fluid, a fibrin clot

lysed in a tube. No longer is a human body fully dissected or are frogs, cats, or dogs examined in the living state. Today's students witness only one or two postmortem examinations at the most.

Medical students obviously cannot recreate all relevant physiologic, pharmacologic, microbiologic, or other experimental procedures. Yet, students could design and complete a sufficient number of laboratory exercises involving use of the brain as well as the hands, which would help them understand how difficult it is to establish the validity of a scientific fact. How can students comprehend the value and interpretation of laboratory methods or question their accuracy unless they have engaged in them and understand the pitfalls and variants of normal? There is no mystery as to why medical students, who later become house officers and practitioners, order tests promiscuously. They know little of the advantages and flaws of computer printouts because they do not fully comprehend the complexities and evolution of this technical knowledge. Under properly supervised conditions, students can profit by performing a few essential procedures; their efforts can lower costs with the added benefits of experience for the students and service for the hospital and patients.

Early tracking. Another reason for inadequate physician training is the encouragement of "early tracking" to specialties. Soon after midcentury, the availability of high fellowship salaries encouraged many students and house officers to enter specialties before gaining adequate general experience. Although the well-organized teaching services persisted in comprehensive instruction, the students who "tracked" too soon sacrificed achievement of in-depth capability in favor of specialization. Indeed, the senior year in many medical centers is a hodgepodge of subspecialty experiences for varying short periods. Return to a postgraduate year of

Commentary

I agree with Dr. Woodward completely: the science of medicine has overtaken the art of medicine to the detriment of medical practice and the welfare of our patients. In addition, the medical liability problem has eroded medical care to a point that only the science of medicine seems to count. As a consequence, we are all apprehensive about acting on what we know is right, correct, and wise.

As vice chairperson of the board of Medical Mutual Liability Co., and a member of its claims committee, I observe examples of this artifact every day. Those of us involved at a level where we can make a difference need to commit ourselves to help ensure that physicians are trained as physicians and are competent in the art of medicine.

I am deeply indebted to Dr. Woodward for helping instill in me the basic principles of medicine. I will never forget the short years spent under his guidance. His article has rekindled in me a deep-seated fire to do what I can for the practice of medicine in whatever way possible. My current position brings me in contact with responsible legislators in Maryland, Washington, D.C., and elsewhere. Be assured of my intent to emphasize throughout the country the principles stressed in Dr. Woodward's article.

DONALD T. LEWERS, M.D.

Dr. Lewers, a past president of Med Chi, is a member of the American Medical Association board of trustees. ■

undifferentiated house officer training would well serve all fields. A well-structured, disciplined, and modified rotating internship also would help prepare and ensure both better generalists and specialists.

It takes time to educate and mature a physician; four years of medical school are just the start. This short exposure must provide for the acquisition of sound principles, inculcate the sense of care and consideration of the patient as a person, and stress the quality of thoroughness and the ability to think. With solid grounding and effective guidance, the average medical trainee reaches a creditable level of clinical competence two years following graduation and completion of high-quality house officership. All that is needed to achieve this desired goal is an institution with patients and reasonable facilities, and a commitment by student and clinical teacher. Gifted as well as average students profit from contact with devoted and stimulating teachers. The house officer years can blossom on this firm base provided there are a few role models to help guide the way.

Reshaping medical training

Senior year. The senior year in medical school should be structured broadly to provide students—particularly those training for medical practice—with ample practical experience in general medicine, surgery, pediatrics, gynecology-obstetrics, preventive medicine, and psychiatry. Two systems are compatible in any academic department: the standard training program in internal medicine and a second track for the community-oriented internist.

First postgraduate year. During the first postgraduate year, primary care physicians should be offered an internship option that provides a minimum of six months in medicine, two months in pediatrics, two months in surgery (including emergency medicine), one month in psychiatry, and one month in gynecology-obstetrics. Beginning in this year, candidates should visit the ambulatory clinic weekly and establish continuity of care for some patients. Good departments of medicine, surgery, and pediatrics with active outpatient clinics can easily accommodate this option.

Second postgraduate year. During the second year, physicians should be provided six months on a busy in-hospital service and six months in a busy outpatient ambulatory service with practice in primary and continuing care. This will expose physicians to medical audit techniques, management skills, physical therapy, and basic preventive health care standards, including vaccine use. During the six-month outpatient assignment, physicians should make a weekly visit to the neurology; gynecology; ear, nose, and throat; and ophthalmology clinics, as well as the subspecialty clinics including cardiology, gastroenterology, endocrinology, rheumatology, and dermatology. When serving in-hospital, there should be weekly visits or continued longitudinal care of assigned patients.

Third postgraduate year. The third year can be programmed according to physicians' needs and interests (e.g., preparation for practice in a large community with a group practice in general medicine, or for solo practice in a small community). It could embrace more general medicine with experience in the emergency room, intensive care unit, coronary care unit, and neurological intensive care unit. Two months of experience in an affiliated community hospital, preferably at a site where the candidate will practice, is desirable. In addition, physicians should continue to visit the general medicine clinic weekly for ongoing care of assigned patients.

It would not be too difficult for the various medical disciplines to reshape training programs for candidates who choose to be primary care or comprehensively oriented physicians. Training experiences for community-oriented internists would broaden their technical capabilities and services to include the ability to perform proctosigmoidoscopy, laryngoscopy, tonography, Papanicolaou (PAP) smears, hepatic (only with sufficient training) and external tissue biopsy, thoracentesis and pleural biopsy, and abdominal paracentesis and peritoneal biopsy, as well as the ability to take and interpret electrocardiograms and perform basic pulmonary function tests. If one accepts the concept that training in good medicine and clinical departments is comparable, the above schedule should be acceptable for fulfillment of requirements for examination by the American Board of Internal Medicine. There are also opportunities for various options; for example, incorporation of training in obstetrics would probably fulfill requirements for the American Board of Family Medicine.

Teaching, research, and patient care. An administrative structure that fully endorses an environment of scholarship and learning is essential to success. There is no question that full-time academicians, including department heads, should render patient services. Indeed, they should be recognized as leaders in the field. The practice aim and dollar return, however, should not outweigh academic pursuits. Physicians are not providers, they are physicians; patients are not consumers, they are patients. If a physician's primary responsibility is to generate funds through patient services, teaching and research will be relegated to secondary roles. Teaching hospitals should not be developed in the image of private clinics. Research by clinical teachers is essential to a university medical center. Service income is not an evil concept, but it should not be the heart of that which constitutes excellence. Teaching, relevant research, and high-quality patient care are essential ingredients for a first-class system. Without any of the three, mediocrity is the rule.

Dr. Samuel Clagett Chew, chairperson of the department of medicine at the University of Maryland in the late nineteenth century, criticized medical schools, including his own, "whose students with respect to chemistry had never handled a test tube

or a retort, as regards their physiology had never seen the action of gastric juices, the pulsation of the heart, the circulation of the blood and the response of any nerve to stimuli, as regards surgery had never lanced an abscess, as regards medicine had never heard a crepitant rale or a cardiac murmur." In 1906, Dr. Chew said: "Now all of this has changed, attendance on the course of instruction is obligatory, laboratory work for chemistry and histology is required for all students, bedside instruction in surgery and medicine, clinical teaching, that is, in the true and liberal sense, is imparted to all. It is incredible that the former system could have maintained for so long. Speaking in behalf of the University of Maryland that condition of things will never be returned to."¹

Dr. Chew would be an unhappy man were he to observe what is happening in American medical education today: the watering down of basic and clinical science instruction, often with the attitude that only enough must be taught and learned to get the student by, rather than attempts to encourage a scholarly curiosity to comprehend everything possible. If we allow the attitude to persist that internists do not need to know things about specialty medicine, that specialists need to know only a little about general medicine or surgery, or that family physicians do not need to know fundamentals but only applications, distinct classes of physicians will continue to evolve, much to the detriment of American medicine.

In my opinion, the medical profession must return to the principles that ensured its position of eminence and respect, through service. The acknowledged gains in medical science and practice that began in the early twentieth century gave the public better individualized care, health, and longevity. Now the profession has the tall order of delivering comparable comprehensive care at lower costs for everyone.

Reference

1. Chew SC. *Medicine in the Nineteenth Century. Book on Addresses.* Deutsch Company. 1906.

Acknowledgement

The opinions in this article have been gleaned from the privilege of having trained under and observed highly qualified physician-educators, as well as over five decades of teaching medical students and house officers, working with faculty associates, visiting other institutions, attending national conferences on educational problems, and participating in committee deliberations too numerous to count. ■



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Ten components for reshaping medical education

Nancy E. Gary, M.D., M.A.C.P.

*Dr. Gary is executive vice president
and dean of the Uniformed Services
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F. Edward Hébert School of Medicine
in Bethesda, Maryland.*

Medical schools are educational institutions with a social purpose. Their responsibility, entrusted to them by society, is the selection, education, and certification of students who will serve the public as their physicians. The education of medical students must be done well. Anything less is not to fulfill the institution's share of its public trust. Society expects, after a period of postgraduate medical education, that the products will be superbly competent physicians who will provide, care for, and promote healthy lifestyles for all citizens of this nation in all its topographically and demographically diverse areas.

Embracing the "new biology" and cutting-edge scientific technology, the era of medical specialization has flourished and the quality of medical care afforded to many of the ill is more sophisticated and more expensive than ever before. It is clear, however, that basic, broad-based, general medical care is not available to many segments of society. The numerous reasons for this should be well known to readers of the *Maryland Medical Journal*. Medical educators have been in the business of preparing physicians to practice in the 1960s, an era characterized by in-hospital, fee-for-service, highly specialized, technologically dependent, brief encounters with patients. Public policy makers and medical educators all agree we need a new direction to produce more generalist physicians and especially those who are willing to serve in the inner cities and less densely populated, geographically remote areas of the country.

The basic educational model is not broken; indeed, it has been very successful! Introductory college science, followed by medical school basic sciences, teaches the student to think like a scientist—deductively. The period of clinical education begins the process of professionalization and completes the training of the thinking process—to reason inductively. It is the content matter and the way it is presented that needs attention in today's educational programs.

The word *dean*, in its simplest definition, means 'chief of ten'. As a dean, I shall propose 10 events that should be components to reshaping physician education for the second millennium.

First, the acquisition of certain biomedical facts is absolutely necessary to build the database of information upon which a physician relies to understand disease, its diagnosis, and its treatment. But the concepts of how humans function in health and disease are the basic units upon which clinical medicine is learned. The highly specialized nature of the knowledge gained from contemporary research is quite removed from the body of information used by physicians in the daily practice of medicine. It is time that faculty scientists and physicians embark on a collaborative reexamination of the basic biomedical science content necessary to educate an undifferentiated physician.

Second, clinical education has to be de-specialized. We have, in the last three decades, filled our clinical ranks with teams of specialists, subspecialists, and super-subspecialists. Often without the guidance of a generalist, the student-resident team is left to integrate the recommendations, sometimes conflicting ones, of a series of consultants who are each taking care of an organ system with which they have chosen to develop special expertise. A greater portion of clinical education needs to be conducted by the generalists, and they need to change to a case-management model so that young physicians can learn integrated care of the whole patient.

Third, physician educators need to practice and teach high quality, cost-effective care. Medical students do need to be exposed to high-tech medicine, but only after they have grasped the fundamentals of data gathering, synthesis, selective use of diagnostic studies, and principles of therapeutics. We often forget that medical student education is only a part of the continuum of learning and much of specialty and technical medicine can be learned later. Both undergraduate and postgraduate education need to include the principles of quality assurance, resource utilization, and cost effectiveness.

Fourth, now more than in the past, physicians devote increasing time and expertise to dealing with medical problems that are inextricably bound to social dilemmas. The increasing numbers of individuals with acquired immune deficiency syndrome and/or substance abuse and the ill and frail elderly will pose special problems for the financing and delivery of health

care in the United States. Not only do physicians need to be biomedically and socially well informed about how to care for patients with medical and socially intersecting problems, they must also be knowledgeable enough to develop and influence overarching public policy issues that affect these populations. Other conditions such as alcoholism, mental illness, environmental hazards, human abuse, and violence require combined medical and social approaches for effective management. These topics deserve greater emphasis in the medical school curriculum.

Fifth, in the absence of a federal mandate, we have entered an era of swift changes in the delivery and financing of health care—from solo, fee-for-service practice, to capitated, managed-care models such as health maintenance organizations, preferred provider organizations, independent practice associations, and physician hospital organizations. It is clear that managed care and coalitions of health care professionals will be the central feature of tomorrow's practice, and we need to prepare physicians to practice in this environment. It is time to weave into the curricula of medical school and graduate medical education the information and skills necessary for graduates to be effective in these new surroundings. Military treatment facilities have long been a model of managed care and should be looked to for elements to develop such an instructional program.

Sixth, some clinical teaching must be moved from the tertiary care, academic health sciences center to the community, where the vast majority of physicians practice. Instructional sites in rural and urban areas should include physicians' offices, community or county clinics, and managed care facilities.

Seventh, the changing demography of the population will dictate changes in medical education. The multicultural diversity of patients to be cared for by medical school graduates needs attention in our educational offerings. Understanding the culture, beliefs, morals, and traditions of individuals, families, and social groups with whom physicians will interact is a necessary component of delivering good health care.

Eighth, students and physicians need to be educated about and responsive to health policy development, health care financing, and the needs of the nation. Physicians must represent patients in health care debates because there are some segments of our society that otherwise will not be heard.

Ninth, the art of medicine, learned through observation and participation in the relationship of a physician with a patient, must not be lost. It is this bond of intimacy between the physician and patient that permits physicians to best serve their patients.

Tenth, whatever scientific, social, economic, or political pressures come to bear on the practice of medicine, and thus affect the teaching of medicine, the process should be enjoyable. Whatever curricular or experiential changes are woven into the tapestry of gaining physicianhood, I hope that it will always remain fun to learn and practice this honorable profession.

For these ten events to be considered in revising today's medical education programs, a change in faculty thinking—away from traditional academic models to more contemporary and imaginative ways to present carefully selected information in a variety of instructional settings—needs to occur. Additional financial resources to support faculty and training sites will probably be required by many institutions. The overarching goal of medical education is to prepare students for lifelong learning and contemporary professional practice that will benefit the health and well-being of the nation's citizens.

The opinions or assertions contained herein are the private views of the author and will not be construed as official or as necessarily reflecting the views of the Uniformed Services University of the Health Sciences or the Department of Defense. ■

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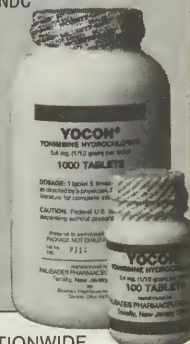
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The status of medical education

Michael M.E. Johns, M.D.

*Dr. Johns is dean of The Johns Hopkins
University School of Medicine.*



This is an exciting time of challenge and change in medical education. And while many changes are being driven by economic considerations and health care reform, many more are occurring as a result of new medical technologies that are fundamentally changing the practice of medicine. The convergence of these two trends means that medical education will change at every level—from medical school through residency and continuing medical education. The next 10 years will be a time when we rethink what it means to be a physician and how we design a course of education and training that will produce the physicians society needs.

The growing costs of health care and the resultant inequities in access and ability to pay have generated a strong health system reform effort, which, regardless of its final form, promises to require more generalist physicians who can provide high quality primary care and make appropriate referrals to specialists. Yet, vast advances in diagnostics and rapid advancements in genetic medicine, coupled with the new demands of practicing within managed care systems, require a new paradigm of generalist training and generalist practice. They must be generalists who can serve the very demanding gatekeeping function, but who also have a special, identified expertise that will enable provider organizations to render more efficient and effective care. Better phrased—generalists will be a gateway to health care.

At The Johns Hopkins University School of Medicine we have already instituted significant changes in our curriculum to ensure that we will provide the best training for new generalists. We have developed new courses and new clinical rotations in a variety of general practice settings. Many other medical schools are undertaking similar reforms. This is an exciting educational challenge and we expect to have some of our best and brightest students pursuing such training.

But we will not stop—and must not stop—training specialists. We must continue to train a solid core of specialist clinicians who will be critical to patients who require their specialized knowledge and skills. They will be a vital part of the patient care system that will deliver the right care at the right

time to the sick patient. And we must continue to train and support a strong core of physician scientists and clinical investigators who will continue to pioneer new advances in medicine and technology.

Residency training, too, will change considerably. We will have to learn to train physicians to work within managed care and capitated environments: settings with new rules that require a new balancing of the needs or desires of the patient within limited community or provider resources. Specialists and generalists will have to learn and develop new relationships. We must find new ways to provide sufficient training in ambulatory care and to assure the proper financing of such training. Team medicine will be an important paradigm for postgraduate training.

The explosive growth of molecular genetics and the rapid development of new diagnostic and therapeutic technologies means that medical education will have to be a lifelong avocation for most practicing physicians. Continuing medical education, already an important part of many physicians' professional lives, will become even more important. The best new technologies will be ever more effective and cost efficient. They will be necessary to a cost-effective practice. Lifelong learning must be coordinated through academic centers, and new teaching technologies, including computerized telecommunications, must be more widely dispersed and utilized.

Since there is growing evidence that we probably already have too many physicians for our population, the number of new training positions likely will be reduced from today's number so as to begin to limit the growth of the physician workforce. Yet, while we train fewer physicians, we will have to teach them more: more about the economics of practice; more about the ethical and the legal implications of new practice environments and the care provided within them; and more about the relationships between the health care system and other major priorities of our society.

The day of the solo practitioner appears to be rapidly coming to an end. Soon almost all physicians (for better or worse?) likely will practice within institutional settings: group practices, HMOs, academic centers, and various other provider organizations where many different priorities will impinge upon what was once a relatively autonomous practice environment. The challenge for medical education is to prepare physicians for these new challenges and changes while also preparing them for leadership in medicine and society. It's a daunting challenge, but an exciting one, perhaps not unlike the challenge Dr. William Osler and his colleagues at Johns Hopkins faced just over 100 years ago when they established the training model that revolutionized medical education.

Will we now have the courage and conviction to undertake such momentous changes? I think we will. We must. ■

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Medical education: A commentary

Donald E. Wilson, M.D., M.A.C.P.

*Dr. Wilson is dean of the University of
Maryland School of Medicine.*

Following the famous report on medical education by Abraham Flexner in 1910, two-thirds of the nation's medical schools rapidly closed; those at the University of Maryland (the oldest in Maryland) and Johns Hopkins were the only survivors of seven Maryland medical schools. Flexner commented: "For twenty-five years past there has been an enormous over-production of un-educated and ill trained medical practitioners. This has been in absolute disregard of the public welfare and without any serious thought of the interests of the public."

Following Flexner's report, we saw the professionalization of medical education. Medical schools had small full-time faculties. Research was relatively uncomplicated by today's standards and played a smaller role, so that even faculty with significant clinical interests could engage in research. Teaching was regarded as a major responsibility, and much of the clinical teaching was performed by voluntary faculty. After World War II, the United States invested heavily in biomedical research. New investigators were trained and research facilities were built. The National Institutes of Health budget increased from \$3 million annually in 1950 to \$7 billion in 1989. During the 1960s and 1970s, the number of medical schools increased from 86 to 125. Medical faculties expanded more than 15-fold from 1960 to 1985, and the number of students increased two and one-half times.

Perhaps it is time for a new Flexnerian study. Today an applicable paraphrase of Flexner's statement might be that for some years past, there has been an enormous overproduction of highly-trained specialists, ill-trained as medical practitioners. This has occurred largely in disregard of the public welfare and without serious thought of the interests of the public.

The current medical education debate is fueled in part by paradoxical realizations. Scientific advances have resulted in a level of sophisticated health care undreamed of just a decade ago. However, we pay more for our health care than any other industrialized nation, nearly 40 million Americans lack health insurance, and access to our sophisticated care is uneven. Public expectations are so high that many patients do not believe that physicians should ever fail to cure or prevent an undesirable event. While

most people think their own physician is quite good, they have serious doubts about the quality, commitment, and knowledge of physicians in general. By some, we are considered to be uncaring, disease-oriented, and ill-prepared to promote health, and worse, primarily interested in our own welfare.

Many are convinced that altering the medical school curriculum can cure not only these perceived ills, but the current generalist/specialist and geographic physician imbalances. In a 1989 Louis Harris survey, a majority of medical educators indicated the need for "fundamental change" and "thorough reform" in medical education. At least 12 major national commissions over the past 50 years have made observations such as, "Medical education has kept only fitful pace with changes in biomedical science and health care needs." In 1991, the Robert Wood Johnson Foundation's commission on medical education issued a report recommending integration of the sciences of medical practice throughout medical school, training beyond the tertiary-care hospital, evaluation techniques compatible with educational goals, and an organizational authority for the educational enterprise. The pressure to change medical education to become more congruent with the health care needs of populations and communities, as well as individuals, has resulted in great discussion and curricular changes at a number of schools.

When I became dean at the University of Maryland School of Medicine (1991), I was presented with two separate committee proposals to change the curriculum. The proposals, one old, awaited implementation by the "new dean." There were those who wanted curricular change and those who wanted to keep the status quo. When I reflected upon my own traditional experiences as a medical student 30 years ago and reviewed Maryland's curriculum, I concluded that changes were indeed warranted. We are now involved in a major curriculum restructuring.

Why can't the same traditional methods of education continue to be used today to educate our students? In three decades, our knowledge of medicine and our research and diagnostic technology have changed so dramatically as to be almost unrecognizable. Medical education must also change in order to prepare students to take advantage of continuing advances. In a practical sense, there is infinitely more to know now; in addition, we have outstanding opportunities to have a real impact on human suffering, disease, and longevity. A major change will be in information technology. In the future, the computer will dominate most aspects of medical practice. Medical education will have to adapt to these changes.

How then can we best educate and prepare physicians to maximize their scientific potential and best serve constituents in the future? It is no longer acceptable to teach the first two years of medical school in a non-integrated manner primarily by lecturing students; asking them to regurgitate materials memorized from lectures, syllabi, and textbooks; and then

accepting the completeness of this regurgitation not only as an indication of their current understanding, but also their future ability to encode new material. As biomedical information increases, some balance has to be struck in the curriculum between emphasizing the long established and the new. Nobel prize winner Sir Henry Dale spoke of the "central problem of medical education today—how to ensure that the student shall continue to acquire a sufficiently competent grasp of what is really essential, out of the mounting superabundance of what is known, and at the same time to sharpen rather than satiate his appetite for further development of knowledge, and to simulate rather than to quench any spark of imagination, any faculty of mental enterprise, with which nature may have endowed him."

We must develop a curriculum that will emphasize equipping students with the motivation and ability to engage in a lifetime of learning, if they are to be successful in their chosen areas of clinical practice, academics, and research. Medical students need to be taught explicitly about decision making in order to be prepared for the changing health care environment. With appropriate guidance from teachers, problem-based learning will allow students to better achieve their own learning goals and objectives by working together in small groups. Students can be continually assessed as they acquire new skills, knowledge, and ability. Flexner anticipated that such a methodology would work because, as he said in 1910, "There is no cement like interest, no stimulus like the hint of a practical consideration."

This is not to say that we should throw out the enormous amount of information that provides the basic tools for understanding complicated information. Nor must we do away with major didactic presentations that are effective in disseminating information with an economy of faculty time. Fundamental in the implementation of curricular change, however, is accepting that a large percentage of today's factual knowledge is unnecessary at this stage of graduate education, is rapidly forgotten, and will likely be incorrect within a relatively short time. Far more important is the ability to understand function and to secure and understand knowledge when it is needed.

A number of areas need increased emphasis in our curricula, including medical ethics, preventive medicine, nutrition, environmental medicine, and health care delivery and policy. Biomedical ethics should become integrated into the curriculum from year one until the completion of postgraduate training. Ethics should cover a broad range of issues, including discussions on scientific integrity and health care policy, as well as interactions with patients and colleagues, in order to prepare future physicians to deal with increasingly complex questions. The ambulatory arena also must play a much greater role in education. Students need to spend time dealing with the patient, as well as with the patient's illness. The reality of inpatient hospital care today mitigates against long-term rela-

tionships and provides our students with patient interactions under the most adverse of circumstances. Just sending students to large hospital clinics will not provide the appropriate milieu to develop a caring health care provider. Well-organized community health services with dedicated faculty, multidisciplinary interactions, and relationships with appropriate private practitioners in their offices should be explored. One anticipated side effect may be an increase in the number of students viewing prolonged interactions with patients as positive and therefore an increase in the number of physicians seeking primary care as a career choice. Teaching of preventive medicine should be significantly expanded in the medical curriculum. Our nation's graduating medical students constantly tell us that they have received insufficient information about nutrition, preventive medicine, and health care costs and policy in medical school.

Curricular changes will require more faculty teaching time and increased financial support to provide appropriate rewards for teaching faculty and to recruit new faculty. For example, I estimate that at Maryland we will require approximately \$2 million annually to support our revised curriculum. During these times of budgetary constraints and changing finances related to health care reform, it is not certain that there will be enough support to accomplish these changes. It is important to remember that it is never easy to implement major changes. There has never been a well-controlled study in medical education. As we evaluate new curricula, we must be careful not to judge their success using tools that are incapable of evaluating the new process.

Society expects much of medical schools and even more of their graduates, who are required to show diverse skills and abilities. I can think of no greater demand on medical schools than to graduate skilled, sensitive, committed, diverse physician-scholars who are equipped to succeed in a lifetime of learning. ■



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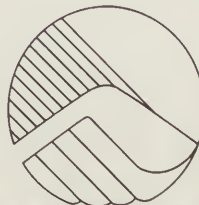
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Maryland medical license renewals, 1994: Continuing medical education requirements

John B. De Hoff, M.D.

*Dr. DeHoff is staff medical consultant
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Assurance, Baltimore, Maryland.]*

CContinuing medical education (CME) maintains and increases the knowledge and skills that a physician must have to meet patients' needs. That education includes basic medical sciences, disciplines of clinical medicine, and the provision of health care to the public. CME has never been more important to quality of care than it is today, given the rapidly advancing medical knowledge and changing modes of practice. Medical licensure reflects these professional concerns and requires that each physician obtain a specified minimum of CME credits every two years. This article outlines essential requirements that physicians must meet to qualify for license renewal in Maryland.

Renewal 1994

During the period July through September, more than 12,000 physicians whose last names begin with the letters *A* through *L* will receive application forms for renewal or reinstatement of medical licenses. These physicians must renew their Maryland medical licenses by September 30, 1994. The Board of Physician Quality Assurance (BPQA) requires that each renewing physician certify to having earned at least 100 CME hours, with a minimum of 40 credit hours in Category 1, during the two years preceding the date of application for licensure renewal or reinstatement. The remaining 60 credit hours may consist of Category 1 or Category 2 credits or a combination of the two. The physician's signature that certifies CME in the renewal application also affirms that the information is true and correct to the best of the physician's knowledge and belief. A false report may result in disciplinary action by the BPQA, under authority of the Maryland Medical Practice Act. Section 14-404(a)(11) of the Act permits the BPQA to reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee willfully makes or files a false report or record in the practice of medicine. False certification on a licensure application is considered to be covered by this section of the act.

Renewal 1995

A slightly different CME requirement will apply to physicians whose last names begin with the letters *M* through *Z* when they apply for renewal or reinstatement in July through September 1995, as well as succeeding licensees. New licensure regulations, effective August 1, 1994, will require a physician to have completed 50 hours of Category 1 CME credit during the two-year period immediately preceding renewal or reinstatement, but other CME categories will no longer be required. Physicians to be relicensed in 1995 and thereafter should plan now to meet the new requirement of an additional 10 Category 1 credit hours every two years. Details of new general licensure regulations, including 1995 CME requirements, were published in the *Maryland Register*, May 13, 1994, volume 21, issue 10, pages 864-871, which may be available in many public libraries, hospitals, and medical societies.

Category 1 credits for 1994 renewals

Credit hours are authorized by the Accreditation Council for Continuing Medical Education (ACCME) or its delegate agencies (e.g., national and state medical societies, medical schools). Local medical societies and hospitals, as well as professional

Local and area-wide ACCME-accredited educational opportunities abound. The *MMJ* lists regional CME programs each month. Additionally, physicians can call their local medical societies, hospitals, medical schools, and professional associations for information about current CME programs. Physicians also may contact Ms. Joan Mannion at Med Chi (410-539-0872) for information concerning CME opportunities in Maryland.

In addition, any physician can subscribe to the following ACCME-accredited learning programs:

- ❑ Audio-Digest Foundation, a subsidiary of the California Medical Association, 1577 East Chevy Chase Drive, Glendale, CA 91026 (1-800-423-2308). It has offices in Canada and Australia and claims over 6,000 overseas subscribers to programs on cassettes.
- ❑ *Journal Watch*, a publication of the Massachusetts Medical Society, 1440 Main Street, Waltham, MA 02154-1649 (1-617-893-3800).
- ❑ CME program of the *New England Journal of Medicine*, P.O. Box 9150, Waltham, MA 02254-9950 (1-800-843-6356).
- ❑ Self-assessment program and *DISCOTEST II* of *Scientific American Medicine*, P.O. Box 5911, New York, NY 10164-0680 (1-800-545-0550).

journals, also may be designated sponsors to award Category 1 credits for specific programs.

Physicians should examine CME course announcements and brochures or check with program sponsors to determine if the program is accredited and the number of Category 1 credit hours that can be earned. Formal scientific meetings of professional societies are usually accredited, but the meetings of boards or administrative committees are not.

Self-instruction to prepare for an approved specialty board certification or recertification examination under the American Board of Medical Specialties (ABMS) that occurs solely within the two years preceding the application for renewal earns one CME Category 1 credit for each five hours of study, up to a maximum of 10 credit hours. The actual taking of board examinations does not earn credit hours.

In Canada, all CME activities that are accredited by medical schools are accepted by the ACCME. Programs of other Canadian sponsors, such as professional societies or academies, are not ACCME-equivalent. Activities sponsored by an international society may be acceptable if they have ACCME approval or are cosponsored by a U.S. medical society or medical school.

CME obtained overseas or in countries other than Canada must have prior ACCME or delegate agency accreditation to earn Category 1 credit hours. Sponsors must issue appropriate certificates of attendance and completion if either Category 1 or Category 2 credit hours are to be earned.

Residencies or fellowships, when accredited by the Accreditation Council on Graduate Medical Education (ACGME), earn 50 Category 1 credits per year of approved full-time study. When approved by the BPQA, acupuncture courses earn one Category 1 credit hour per hour of training, to a maximum of 10 credit hours.

Category 2 credits for 1994 renewals

Certain educational experiences not certified or accredited by ACCME or a delegate agency may be claimed as Category 2 credit hours. Attendance at regular teaching rounds for which a hospital did not seek ACCME accreditation earns one Category 2 credit per hour of rounds. Presentation of a medical exhibit at a professionally-related event or medical or medically related articles published in a recognized medical journal earn 10 hours of Category 2 credits for preparation of each presentation or publication. Designated teaching in undergraduate, graduate, and continuing education for health professionals earns one Category 2 credit per hour of instruction. Departmental memorandums that designate the individual as a teacher or speaker at teaching rounds in well-documented schedules, and letters of appreciation for teaching assignments, should include dates of teaching, number of hours, and sites. Official participation in formal review and evaluation of

patient care, as on hospital committees or boards, earns one Category 2 credit per hour served.

Licensees residing or working outside the United States

Physicians who possess Maryland licenses and reside or work in other countries also must meet Maryland CME requirements for license renewal. Although the ACCME does not now accredit ongoing training experiences conducted by professional societies, medical schools, or hospitals of countries other than the United States, CME opportunities acceptable for licensure do exist for nonresident physician licensees. For example, physicians can request CME sections of medical specialty societies to provide lists of U.S. programs that can be completed by mail for CME credit. In addition, the California Medical Association and the Massachusetts Medical Society, as well as the *New England Journal of Medicine* and *Scientific American Medicine* offer ACCME-accredited learning programs to which any physician can subscribe (see box for further information).

Noncredit experiences

No CME credit is granted for taking specialty board examinations. Although secondary awards that summarize or recognize CME experiences (e.g., the American Medical Association's Physician Recognition Award) are not acceptable, CME documents submitted for these awards should be kept in the physician's CME file. Unless ACCME-accredited, training in alternative medicine (other than acupuncture), ethnic health disciplines, or religious health systems does not earn CME credits. Service on administrative or governing councils, boards, committees, or task forces of societies, associations, hospitals, medical schools, or other health organizations does not earn credit hours unless the service was an essential part of patient care review and evaluation.

Assembling CME information

Regulations require that records of completed CME programs be retained for the six years that follow license renewal for possible inspection by the BPQA. Thus, a licensee should have a CME file in which all pertinent information concerning CME experiences can be stored and easily retrieved. Each key document should report that the physician has attended and completed an ACCME-accredited CME educational experience. Each CME certificate should be placed in the file as it is received and the total accumulated credits reviewed from time to time to ensure that sufficient credits are being obtained for biennial license renewal. In this fashion, a "paper trail" of learning experiences is created that will aid renewals and simplify any subsequent audit.

Certificates of attendance at accredited events should include location of the CME event; CME category and accreditation; designation of number of credit hours awarded; and documented verification by an official note or statement of successful completion. Course announcements, receipts, hotel bills, or plane tickets are not acceptable documentation. ■

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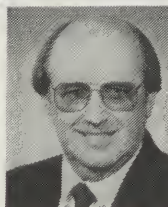
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Accreditation of continuing medical education programs in Maryland

Deusdedit L. Jolbitado, M.D.

Dr. Jolbitado is a member of the Continuing Medical Education Review Committee of the Medical and Chirurgical Faculty of Maryland.

The Continuing Medical Education Review Committee (CMERC) of the Medical and Chirurgical Faculty of Maryland (Med Chi) was formed in the early 1970s to review and evaluate whether intrastate CME programs substantially comply with the standards (currently the Essentials) and guidelines for Med Chi accreditation. In the 1980s, the CMERC started the accreditation process using the seven essentials used by the Accreditation Council for Continuing Medical Education (ACCME), from which they were adopted.

The ACCME, formed in 1981, began to accredit review committees such as the CMERC in 1985. The ACCME consists of representatives of several national sponsoring organizations: the American Medical Association, American Hospital Association, American Board of Medical Specialties, Association of American Medical Colleges, Council of Medical Specialty Societies, Federation of State Medical Boards, and Association of Hospital Medical Education. In addition to accrediting Med Chi's CMERC, the ACCME accredits Med Chi's Committee on Scientific Activity, which plans and implements the scientific programs at the annual, semiannual, regional and other meetings. The ACCME also accredits organizations that offer interstate or nationwide CME programs.

Initiating accreditation

The objective of CMERC is to assist intrastate organizations offering CME programs (e.g., local hospitals, city and county medical societies, state specialty medical societies, local units of voluntary health agencies) to achieve accreditation and provide quality CME programs. The accreditation process is voluntarily initiated by applying for accreditation to CMERC. The application is reviewed by staff for completeness and then by physician reviewers who recommend further action (either a request for more information or acceptance of the application) to the full CMERC.

When the application is accepted, trained, experienced CMERC members conduct an on-site survey to determine the overall quality of the CME

The Essentials

1. The accredited organization shall have a written statement of its continuing medical education mission, formally approved by the organization's governing body. The mission statement shall:

- ❑ describe the goals of the overall CME program in a concise manner;
- ❑ indicate the scope of the CME effort;
- ❑ outline the characteristics of the potential participants; and
- ❑ describe the general types of activities and services provided.

2. The accredited organization shall have established procedures for identifying and analyzing continuing medical education needs and interests of prospective participants. It shall:

- ❑ document the processes used to identify CME needs;
- ❑ include data sources which go beyond its own perception of need;
- ❑ state the overall needs identified by the above processes; and
- ❑ indicate how this assessment is used in planning educational activities.

3. The accredited organization shall have explicit and specific objectives (expected learning outcomes) for each continuing medical education activity. It shall:

- ❑ state the educational need(s) which the individual activity addresses;
- ❑ indicate the physicians for whom the activity is designed;
- ❑ list any special background requirements of the prospective participants;
- ❑ highlight the instructional content and/or expected learning outcomes in terms of knowledge, skills, and/or attitudes; and
- ❑ make these objectives known to prospective participants.

4. The accredited organization shall design and implement educational activities consistent in content and method with the stated objectives. It shall:

- ❑ design and implement educational activities responsive to the characteristics of prospective participants, such as knowledge levels, professional experience, and preferred learning styles;
- ❑ document use of systematic planning procedures; and

- ❑ make educational content and methods known to prospective participants.

5. The accredited organization shall evaluate the effectiveness of its overall continuing medical education program and component activities and use this information in its continuing medical education program planning for future activities. It shall:

- ❑ periodically review the extent to which its CME mission is being achieved by its educational activities;
- ❑ show that evaluations assess the extent to which educational objectives are being met, the quality of the instructional process, and participants' perceptions of enhanced professional effectiveness;
- ❑ use evaluation methods which are appropriate and consistent in scope with the educational activity; and
- ❑ demonstrate that evaluation data are used in planning future CME activities.

6. The accredited organization shall provide evidence that management procedures and other necessary resources are available and effectively used to fulfill its continuing medical education mission. It shall:

- ❑ document an organizational structure for CME and its administration, designating an entity responsible for CME and delineating its authority;
- ❑ identify responsible individuals who will maintain continuity of administration;
- ❑ describe an internal review and control procedure, including budgetary practices, to ensure effective utilization of resources in fulfilling the CME mission;
- ❑ provide a budget for the overall CME program and its major components;
- ❑ utilize competent faculty;
- ❑ provide appropriate facilities for CME programs; and
- ❑ have mechanisms to record and, when authorized by the participating physician, to verify participation.

7. The accredited organization shall accept responsibility that the Essentials are met by educational activities which it jointly sponsors with non-accredited entities. It shall:

- ❑ provide evidence that it participates integrally in the planning and implementation of each jointly sponsored CME activity; and
- ❑ conduct an evaluation of each jointly sponsored CME activity.

Accreditation types and duration

Provisional accreditation. If there is substantial compliance with the Essentials, the CMERC awards provisional accreditation for two years. Initial applicant accreditation is always

program and whether it substantially complies with the Essentials. The survey team rates compliance with each Essential in four grades. Following the on-site survey, the team reports its findings and recommendations to the full CMERC.

provisional; during this time, the organization may not jointly sponsor any CME activity with a non-accredited organization. An interim report must be completed and returned to the CMERC midway through the provisional accreditation period. The report is reviewed by physicians and staff. If there is evidence that the CME program continues to be in compliance, the reviewers recommend that the full CMERC accept the report. If there are problems or weaknesses, consultation is provided. If there is no substantial compliance with the essentials, the CMERC may direct an on-site survey. If warranted, the two-year provisional accreditation may be extended for another one or two years after the reaccreditation survey or for a four-year full accreditation.

Probational accreditation. Accreditation for one or two years, not to be extended, may be given to an accredited organization after a resurvey when it is determined or there is evidence that there is noncompliance with the Essentials or when serious problems were identified previously and corrective measures have not been taken by the organization.

Full accreditation. Accreditation for up to four years is awarded to a previously accredited organization following a resurvey in which it is determined to be in substantial compliance with all the Essentials. Four years is the maximum period for which accreditation can be awarded. When accreditation is less than four years, specific reasons must be cited (e.g., certain essentials not substantially complied with) and recommendations for corrective measures must be made. Before the end of the accreditation period, the CMERC sends a reaccreditation application to the organization to be completed and returned by a specified date.

Non-accreditation. Following an on-site survey, if the CMERC determines that there is evidence an initial applicant is not in substantial compliance with the Essentials, non-accreditation may occur. Non-accreditation may not be given to a previously fully accredited organization unless it has been on probationary accreditation and continues not to comply with the Essentials.

Staying accredited

For any organization to remain accredited, there must be evidence of continued substantial compliance with the Essentials, through either submitted interim reports or resurvey for reaccreditation. An accredited organization is required to report to CMERC any major or significant changes in its administration or programs. This alerts the CMERC to provide consultation if needed and to identify problems early.

Requesting reconsideration of an adverse accreditation decision

If non-accreditation is given or accreditation is denied or withdrawn, the adverse accreditation decision is promptly

transmitted by the CMERC to the organization in a letter of notification, sent by certified mail. The letter gives the basis for the decision and informs the organization of its right to file a written request for reconsideration within 30 calendar days of receipt of the letter. The request must be addressed to the chairperson of the CMERC and must specify the reasons for requesting reconsideration. The information on which the request is based must pertain to the organization at the time of the survey or the CMERC's initial consideration of the application. Any new information pertaining to changes in the CME program after the adverse decision or after the survey and review that resulted in the adverse decision will not be considered by the CMERC. If no written request is made, the adverse accreditation becomes final.

During the reconsideration process, the accreditation status of the organization remains as it was before the adverse accreditation decision. The CMERC has 90 calendar days to complete the reconsideration process after it receives the written request for reconsideration. The CMERC must promptly notify the organization of its decision in writing. In the event the adverse decision is upheld, the CMERC also must notify the organization of its right to appeal the decision.

There are two grounds for appeal: (1) that the CMERC's decision was not supported by substantial evidence, or (2) that the CMERC's decision was arbitrary or not in accordance with the accreditation standards and procedures of Med Chi.

If the organization wishes to appeal, it must file a written request for a hearing before the board of trustees of Med Chi.

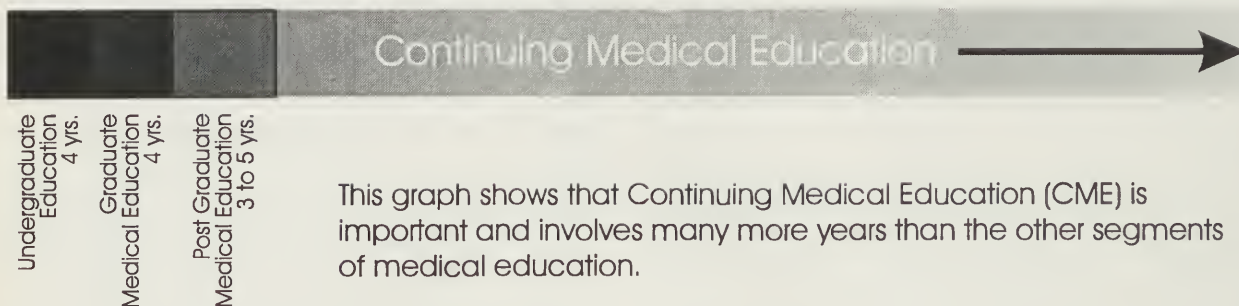
Disclosure requirements:

For all CME activities. An accredited organization shall have a policy requiring disclosure of the existence of any significant financial interest or other relationship a faculty member or the sponsor has with the manufacturer(s) of any commercial product(s) that might affect the educational presentation. All certified CME activities shall conform to this policy.

In conference materials. CME faculty or accredited organization relationships with commercial supporters shall be disclosed to participants prior to educational activities in statements in conference materials such as brochures, syllabi, exhibits, poster sessions, and postmarketing publications.

For regularly scheduled activities. In the case of regularly scheduled events (e.g., grand rounds), disclosure shall be made by the moderator of the activity after consultation with the faculty member or a representative of the supporter. Written documentation that disclosure information was given to participants shall be entered in the file for that activity.

Medical Education



The request must be addressed to the chairperson of the CMERC and received within 30 calendar days of the appellant's receipt of the letter of notification of the action taken at the reconsideration process. If the request for an appeal is not received within 30 days, the CMERC's reconsideration decision becomes final. During the appeal process, the accreditation status of the appellant remains as it was before the adverse accreditation decision.

Appeal hearings must be held within 60 calendar days of the CMERC's receipt of the appellant's written request for a hearing. The appellant must be notified of the time and place of the hearing 45 calendar days before its occurrence. The appellant has the right to request and obtain from its application files information on which the adverse decision was based. New information supplied by the appellant will be accepted for clarification only; it may not include information or changes in the CME program that occurred after the action taken by the CMERC. Written statements may be given to the board of trustees before the hearing, at the hearing, or up to 14 calendar

days after the hearing, provided that a formal request to submit such statements was made to the board of trustees.

The records of the review, the formal presentations at the hearing, the transcripts of the proceedings of the hearing, and statements submitted to the board of trustees are the basis for the board of trustees' findings. The board of trustees must submit a recommendation regarding the appellant's accreditation within 30 calendar days of the hearing. If non-accreditation is upheld, the decision is effective immediately. Otherwise, the board of trustees submits a recommendation as to the accreditation status of the appellant.

Acknowledgement

The author is indebted to Joan Mannion, director of CME, and Sandy Heim, CME administrative assistant, for their assistance in preparing this article. ■

Med Chi Bicentennial Celebrations

Med Chi has already begun planning celebration activities for its bicentennial in 1999. If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at 410-539-0872 or 1-800-492-1056.

Focused professional education

Edward J. Kowalewski, M.D., and Cora H. Teter, M.S.

Dr. Kowalewski is the chairperson of the Committee on Focused Professional Education and Ms. Teter is project coordinator of the focused professional education program and managing editor of Straight Forward, a quarterly publication of the Med Chi physician rehabilitation program.

Since 1991, the Medical and Chirurgical Faculty of Maryland (Med Chi) has conducted a focused professional education (FPE) program as part of its physician rehabilitation program. The goal of the FPE program is to improve the quality of care for patients by providing physicians with educational assistance to improve specific areas of deficient practice. The FPE program continues the effort begun at the University of Maryland to plan, develop, and coordinate specialized educational programs for physicians. This customized medical education provides the best opportunity to help competent physicians who have weaknesses in certain clinical areas.

The program, administered through Med Chi's Committee on Focused Professional Education, receives referrals from a number of authoritative bodies including the Board of Physician Quality Assurance, peer review committees of medical societies, hospitals, and out-of-state licensing board and hospitals. In the case of out-of-state referrals, the program's responsibility ends with completion of an initial evaluation report. FPE provides another option to the disciplinary actions that these authoritative bodies might impose, transforming peer review activities from a punitive enterprise into a network of effective medical education.

Referral

A referral begins with a letter to the chairperson of the Committee on Focused Professional Education containing (1) the reason for the request to enter the program; (2) a statement of who will receive the initial evaluation report; and (3) a statement of who will bear the cost of the initial evaluation.

The referring body or the physician must arrange for the release of background material to the committee chairperson.

The process

Initial evaluation. When a physician is referred to the program, the chairperson of the Committee on Focused Professional Education appoints an initial evaluation team of three to five members, who are the referred physician's peers. The members of the evaluation team may come from the

committee's members, medical school faculty, or specialty societies. The team studies background material on the referred physician and interviews the physician concerning background, practice, view of the current situation, and plans for the future. Each evaluator prepares typical cases that are presented to the physician, who is asked to describe his or her approach, thought process, diagnosis, and recommendations regarding the case. The evaluators may ask the physician to produce a medical record from one of the test cases or may ask for copies of records from the physician's practice.

Each evaluator submits a report to the chairperson, who compiles a committee report that discusses the nature and degree of the deficiencies and whether an educational plan could provide a remedy. The report identifies specific issues to be addressed in the physician's focused education plan and evaluates the apparent willingness of the physician to participate in such a plan.

Education. Every focused professional education plan is centered on interaction between the participating physician and the course coordinator. The course coordinator provides necessary supervision and ongoing evaluation of the participating physician, as well as personal contact, feedback, and an incentive to improve. A focused educational program might include the following activities:

- ☐ attendance at established institutional activities such as grand rounds, educational conferences, departmental meetings, specialty society activities, and other accepted continuing medical education functions;
- ☐ medical school courses;
- ☐ medical recordkeeping course;
- ☐ supervision of patient care through scheduled presentations of representative cases under current treatment by the participating physician; and
- ☐ periodic review of the participating physician's medical records.

The FPE program has maintained ties to the University of Maryland School of Medicine and is currently seeking the cooperation of community hospitals. The program's administrators believe the most successful FPE experience occurs in clinical settings that provide close association with role model peer teachers.

Final evaluation. At the close of each FPE, a final evaluation team examines the program's success in altering practice patterns of the participating physician. The final evaluation team uses multiple means to determine the success of each FPE program, including simulated chart reviews, simulated patient encounters, oral examinations, and objective structured clinical examinations. The course coordinator's ongoing and final reports play a major part in the evaluation. Also, for a physician whose practice undergoes a new peer review at the end of the FPE program, the new review can provide information about the success of the focused education program. The most

important factor in the final evaluation is how safely the physician practices medicine.

The FPE program continues to evolve and grow. The program's administrators are presently reviewing procedures and working on plans to establish clinical training resources at community hospitals throughout Maryland. Securing training sites at the community level will enable the program to evaluate and refer physicians for reeducation in areas convenient to where they live and work. ■

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Vignette of Medical History: The first women's medical school

Joseph M. Miller, M.D.

*Dr. Miller is a retired surgeon from
Timonium, Maryland.*

In 1855, the editors of a Boston medical journal¹ offered some very definite opinions on the abilities of women physicians. They said nature had established limits to the feminine sphere of occupation, that pursuits requiring the exercise of the highest intellectual power—the learned professions of law, divinity, medicine, and literature—were beyond woman's capacity. The editors wondered how it would be possible for a woman to devote the requisite time to household duties and rear a family while practicing medicine. Considering the degree of intelligence, judgment, and courage that a successful practitioner had to possess, it was not surprising to these editors that medical science had been confined almost exclusively to men.

In this view, however, they were mistaken. The early Egyptians accorded equal status to women and men and trained both as physicians and surgeons. Indeed, the first woman physician of record was Merit Ptah (circa 250 B.C.).² The Greeks and Romans also had accepted women as physicians and surgeons. By the Renaissance, this attitude had changed completely; the Church even issued an edict in 1421 forbidding women to practice medicine or surgery. In the United States in the mid-nineteenth century, women still were traditionally excluded from the practice of medicine, except in midwifery.

Like many other great events in the history of the United States, the revolution against male dominance in medicine began in Boston. Turbulence in the professional environment leading to the medical education of women was perhaps first occasioned by Harriot Kezia Hunt,^{3,4} a pioneer physician and reformer born in Boston who felt at an early age that women should have useful occupations. She taught school for six years and then was attracted to medicine due to the illness of her sister, Sarah, who was treated successfully by Dr. and Mrs. Mott, both of whom were English physicians. Under the influence of Mrs. Mott, the sisters studied medicine and in 1836 advertised as doctors with their practice being limited to general hygiene, hydrotherapy, and psychotherapy. After Sarah's marriage, Harriot continued

ed alone. In 1847 and again in 1850, she was refused admittance to Harvard medical school. Although she added little to the practice of medicine itself, Dr. Hunt did serve as a catalyst to the introduction of medical education for women in the United States.

The world's first medical college for women was started in Boston by Samuel Gregory, a self-styled physiologist who was born in Guilford, Vermont. Like many of his colleagues, he taught for a number of years to accumulate funds for a college education, graduating from Yale University in 1840 at the age of 27. While there, he took a series of lectures in physiology and anatomy and returned in five years to earn a master's degree. He then apparently earned a living by writing pamphlets and giving lectures in physiology.

According to data compiled by the American Medical Association,¹ in 1910 only half of U.S. medical schools accepted women. Yale University School of Medicine, for example, prohibited women applicants until 1916, and Northwestern University School of Medicine did not begin to admit women until 1926. In addition, of the 482 hospitals approved for general internship training in 1921, only 40 (8%) accepted women. In 1925, half of all U.S. women interns trained in only nine hospitals, one of which was in the Philippines.²

Over the last two decades, the number of women medical students has increased dramatically. In the early 1970s, only 9% of all medical students were women. By 1992-1993, however, 40% of medical students were women and at nine schools women students were in the majority.³

Enrollment at Maryland's medical schools reflects these national trends. For the 1993-1994 academic year, the number of medical students registered at The Johns Hopkins University School of Medicine was 460; of these, 186 (40%) were women. For the same academic year, the University of Maryland School of Medicine had a total enrollment of 608 students, of whom 297 (48%) were women. Indeed, for the past two years, more than 50% of UM's first-year medical students have been women.

The AMA estimates that approximately 19% of physicians in the United States today are women; by the year 2010, the percentage is expected to be 30%.

References

1. Anon. Women in medicine in America: In the mainstream. Chicago, IL: American Medical Association. 1991.
2. Walsh MR. Women in medicine since Flexner. *NY State J Med* 1990;90:302-7.
3. Anon. Women in medicine data source 1994. Chicago, IL: American Medical Association. 1994. ■

Gregory, who believed that men should not provide care for women before and at the time of confinement, became convinced that he should start a school to train women to do the necessary tasks. Having successfully solicited some funding, he opened the Boston Female Medical College in the autumn of 1848 with four faculty members, a classroom, a dissecting room, some educational supplies, and 12 students. The course of study consisted of two terms of four months' duration in successive years.

During the first two years, about 50 students from the New England states, New York, and Ohio attended the sessions. While Gregory and an assistant tended to the administration, Enoch Rolfe, M.D., (Bowdoin Medical College) taught obstetrics and diseases of women and William Cornell, M.D., (Berkshire Medical College) taught physiology and hygiene. Due to insufficient funds, the school led a nomadic life, with classes often held in students' homes. In 1850, Gregory was able to rent a house for the school for two years.

The Woman's Medical College of Pennsylvania, started in October 1850, also was beset with financial difficulties.⁵ In 1851, it proposed a merger with its Boston counterpart to alleviate their mutual difficulty. A single faculty would provide instruction for both institutions, with the spring session meeting in Boston and the fall session in Philadelphia. In February 1852, the first course was held in Boston with five of the seven faculty members being from Philadelphia. The fall term met in Philadelphia, but Drs. Rolfe and Connell did not participate.

The attempted merger afforded only partial financial relief for the Boston school. It was not until 1855, when the Massachusetts legislature agreed to award 40 scholarships annually to state women, that the monetary pressure was relieved. In May 1856, the corporation's name was changed from the Female Medical Education Society to the New England Female Medical College. The following year, a hospital building was acquired from the city of Boston.

In 1858, Marie Elizabeth Zakrzewska, M.D., accepted the college's chair of obstetrics,⁶ but after three years she became dissatisfied with the lax procedures at the school and left it to start the New England Hospital for Women and Children (which she headed for 40 years). When Gregory died in 1872, the school met with real difficulty and merged with Boston University in 1873.

By any standard, the Boston Female Medical College provided a poor education. It was, however, a wedge placed in the crack of male domination of the medical profession and Mr. Gregory, despite his apparent shortcomings as a medical educator, deserves some recognition as a trendsetter. During the last half of the nineteenth century, 17 women's medical schools were born. By 1903, however, 14 had closed (the last women's medical school, the Woman's Medical College of Philadelphia, became coeducational in 1970³) and there was a sharp decline in the number of women admitted to

coeducational programs. Women who did graduate, hoping to pursue academic medical careers, became lost in the lower hierarchy of teaching institutions. Women also were infrequently accepted into medical societies. Although many of these inequities have progressively been corrected, the transition from the Boston Female Medical College to the present time has been difficult.

References

1. Anon. Females as physicians. *The Boston Medical and Surgical Journal* 1855;53:292-94.
2. Walsh MR. "Doctors Wanted: No Women Need Apply." *Sexual Barriers in the Medical Profession 1835-1975*. New Haven, CT: Yale University Press. 1977.
3. Viets HR. Harriot Kezia Hunt (1805-1875). In: Dumas M (ed). *Dictionary of American Biography* (vol. 5). New York, NY: Charles Scribner's Sons. 1933.
4. Bernstein DM. Women in medicine. *Minn Med* 1992;75:16-23.
5. Alsop GF. *History of the Woman's Medical College, Philadelphia, Pennsylvania, 1850-1950*. Philadelphia, PA: J.B. Lippincott Company. 1950; 385-86.
6. Viets HR. Marie Elizabeth Zakrzewska (1829-1902). In: Dumas M (ed). *Dictionary of American Biography* (vol. 10). New York, NY: Charles Scribner's Sons. 1933; 642. ■

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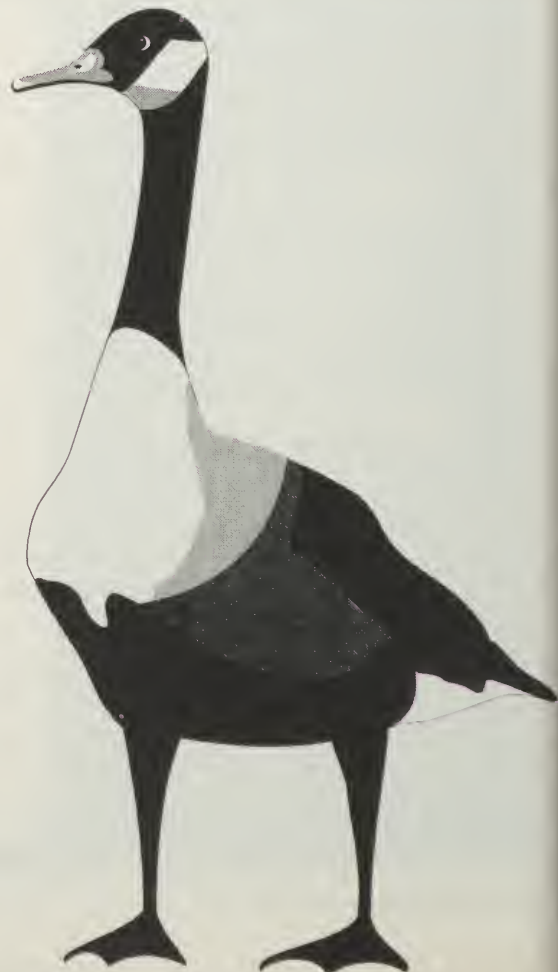


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Dan K. Morhaim, M.D., candidate for the Maryland House of Delegates

This is the third in a series of interviews with candidates running for political office. Maryland Medical Journal associate editor Robert G. Knodell, M.D., met last month with Dr. Dan Morhaim, a Democratic candidate for the Maryland House of Delegates from the Eleventh District in Baltimore County (Pikesville, Owings Mills, Reisterstown, Gylndon, Lutherville, and the Greenspring Valley).

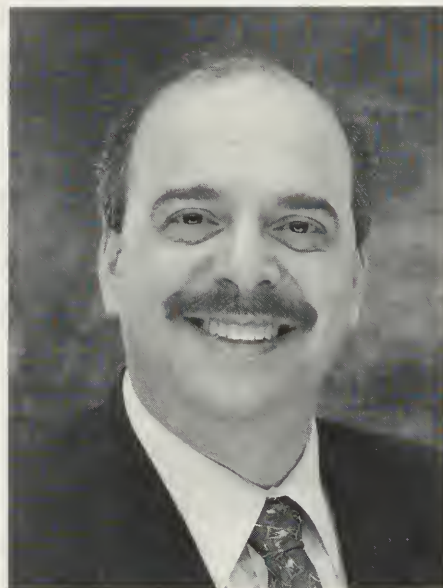
Knodell: The Medical and Chirurgical Faculty of Maryland takes a special interest in members who enter the political arena since they have special expertise with regard to health care issues. It is a pleasure to have you give us an opportunity to introduce your candidacy for the Maryland House of Delegates to the *Maryland Medical Journal* readership. Could you please tell us about your background and about some of your past and current medical experiences?

Morhaim: As a long-time member of Med Chi I am pleased to be here.

I went to medical school at New York Medical College in New York City. My residency at UCLA in Los Angeles, California, was in internal medicine and I immediately went from residency to become an emergency medicine physician. I am board certified in internal medicine and emergency medicine. Thirteen years ago I came to Baltimore. My wife is from here. I became the founder and first chairperson of the then-new department of emergency medicine at Franklin Square Hospital. At that time, the department consisted of just me and I was totally devoted for a number of years to that project. Fortunately, things went very well. I was able to recruit a really excellent staff while receiving great support from the hospital and from nursing. I became involved also in emergency medical system pre-hospital care and I served for seven years as the Region 3 EMS medical director. The success at Franklin Square led our fledgling group to expand; we now staff Franklin Square, St. Agnes, Carroll County, and Atlantic General Hospital in Ocean City, Maryland.

I am a very active clinician. I do about two to four shifts a week, including nights and weekends. I am much involved in both the clinical practice and the group management practice. I am on the faculty of the University of Maryland and at Georgetown in the emergency medicine departments.

Knodell: What got you interested in politics, why this change in direction?



Dan K. Morhaim, M.D.

Morhaim: For me it is not actually a change. I know there are newspaper articles about physicians running for office, and it seems many of them are getting involved because of the imminent changes in health care delivery and health system reform. I, on the other hand, have been a long-time community and political activist. In fact, I would say I'm a community and citizen activist who happens to be a physician, rather than the other way around.

My political activity began in the early 1980s, some of it around the environmental and anti-nuclear war movements, but that involvement translated quickly into local politics. I became a political campaign manager, took the excellent AMA campaign manager school in Washington sponsored by Med Chi, and managed other candidates' campaigns. In 1990, I ran for the Democratic party State Central Committee in my district and won. In 1992, my peers on the Central Committee elected me to the Executive Committee of the state Democratic party.

Along the way, I was appointed to the state recycling commission by Governor Schaefer and was involved in formulating the plan for recycling throughout the state. I also served on the Baltimore City/County Task Force on recycling, which paved the way for the curbside recycling program that is now coming into Baltimore County. I am also involved in the school systems in Baltimore City and

Baltimore County with some educational programs that have to do with the environment and health.

So, I have been working on community issues for a long time. I've found that, because I've been active on these other issues, when I have the occasion to speak directly to citizens and legislators about health care, they know me from other arenas. I think that has helped my credibility with them.

Knodel: What do you think should be Maryland's top health priorities?

Morhaim: There are a number of social issues that are tallied up on the health care side of the agenda in both the media and the common public thinking. This is especially true from my perspective as an emergency physician. A lot of social problems end up being medical problems: alcoholism, domestic violence, homelessness, drug abuse, teen pregnancy, senior citizens having problems taking care of themselves and managing the injuries and illnesses they get, environmental issues concerning allergic reactions, and so on. People also use the emergency room because they lack either the ability or personal responsibility to go to primary care physicians or specialists as they need to.

There is one big social issue that ought to be a health care issue and that's crime prevention. Statistics show that most violent crime is committed by drug addicts seeking money for their next fix. A recent article in the *Baltimore Sun* pointed out that a dollar spent in drug treatment programs is seven times more effective than a dollar spent on drug enforcement. I'm as tough on crime as other candidates because I work with crime victims. We can make a sound investment both as health care policy and as social policy in drug treatment programs.

Knodel: These are obviously far-reaching and very broad social issues. They're problems that aren't going to be solved quickly. What seems to be a pattern in most legislative bodies, at both the state and national level, is looking for quick fixes with no ability to make any tough decisions or any commitment to long-term solutions. What would you do as an individual about effecting some of these social and medical changes that you've pointed out need to be considered and accomplished?

Morhaim: I agree that legislators have historically sought the quick fix and haven't really wanted to raise the tough questions. I'm not here to tell you or any of my potential voters that I have all the answers to everything. What I would try to do is start asking those tough questions, trying to raise both the public and legislative consciousness about them. I think physicians, nurses, and other health

care providers who are on the front lines dealing with these issues have a particularly valuable insight.

There's only one physician in the Maryland legislature and there are a few nurses, none of whom I'm aware are practicing at the moment. I'm still a practicing physician and when I'm elected, I will continue to be. I see my role as helping to educate the legislature about many of these real-world issues and how the laws we make will affect the actual practice and delivery of medicine. That will be a slow process. The problems are complex. Hopefully, I can begin to change perspectives toward a more sound, rational health care policy that's better for all concerned. This is not a time to be adversarial. There's just too much at stake.

Knodel: The federal government, state governments, major corporations, and small businesses all feel an urgent need to control health care costs. Do you have some specific suggestions for bringing health care costs down to a more reasonable level of gross national product? What are your feelings on the current taxation level that's required to fund current social programs and what taxes might be justified to fund some of the social improvements you espouse?

Morhaim: You're asking some complicated, and broad, far-reaching questions. My first answer is, I also understand the employer side because I'm the president of a group practice that employs about 50 doctors and approximately 20 other people. We pay health insurance premiums, so I understand when that health insurance bill rolls in each month and it goes higher and higher. I've discussed health care issues with different organizations and my sense is that there's still a lot of debate that needs to happen. We haven't achieved societal consensus.

Having said that, there clearly needs to be more emphasis on prevention and it can be targeted. Many physicians and nurses know that prenatal care programs for teenagers would save a lot of dollars on the back end. Obviously, continuing programs for decreasing smoking, controlling alcoholism, and treating drug addiction, which I've previously talked about, are really important. We need to look at health care expenditures at the end of life.

We also are going to have to make individuals more accountable and more directly aware of their health care decisions. The public has an almost insatiable demand for services: "I want the best for me right now." But then we don't want to pay for it or we don't want to have it for other people. We ought to recognize there are some inconsistencies there and hold ourselves accountable.

I think physicians need to take an active leadership role in raising some of the issues that I've discussed. I also

think government regulation has gotten out of hand in a number of ways. For example, there was a debate in the Maryland legislature last year about how many physician assistants (PAs) a physician can supervise. They debated for a number of days whether it should be two, three, or four PAs per doctor. This is a waste of time in the legislature. In some settings, let's say an open heart surgery unit, it may be entirely appropriate for there to be one PA to two doctors. There may be other settings where six PAs per doctor may be appropriate, in a prison or a job corps training site, for example. It's not a matter for the legislature to spend a lot of time on.

Knodel: The legislature often seems to spend a lot of time talking about what most rational people would consider mundane and unimportant things to avoid the tough issues. What position or leadership role do you think the government should take to try to reduce smoking, drinking, and violence? And along those lines, what's your position on "sin" taxes, such as a heavy tax on cigarettes that's been proposed but which the Clinton administration now seems to be backing away from?

Morhaim: Generally, I would be in support of sin taxes in terms of legislating societal changes. You can't legislate human behavior, but you can change the system of rewards and penalties for certain behaviors. But I think it ought to be done through a health care model. We are not here to penalize people or make them feel bad; we are here to make them healthier and feel good. That's a long, slow educational process.

I think the role of regulation is a tough issue. In health care, and certainly as a hospital-based physician, I see a great deal of time and energy being spent by the health care system in meeting a variety of different regulations, some well meaning and well intentioned, but often just redundant and wasteful. I would hope that when I'm in the legislature, I'll bring in doctors, nurses, and hospital administrators to discuss further what the impact of various health care bills is and how we can work in more creative or less costly ways.

I also want to say something about malpractice, which is at the forefront of physicians' minds. First, I think as physicians we need to accept responsibility and continue to improve methods to police ourselves. Second, I think we ought to begin to look at a method of malpractice insurance so that those who are truly wronged can get the financial relief they need without a long trek through the legal system. Early on in my practice I was an expert for the defense on a very difficult case in which a pediatrician had to decide whether to intubate a two-year-old with epiglottitis

or croup. This is a very difficult clinical decision and things may or may not work out. The case was settled for \$2 million. But it would have been less expensive and more helpful to the patient to say the physician didn't really do anything wrong, it's just one of those bad outcomes. The child needed the benefit of rehabilitation and assisted living. The case wound through the court system for 12 years and the attorneys took one-third or more of the \$2 million. It would have been better for the child to set up an annuity immediately to give him what he really needed. Instead, the child got no benefit over many years. That's just one example. There are many cases like that where there are better and less expensive solutions to address everybody's needs.

Knodel: What is your opinion of the past legislative session's failure to enact retroactivity for the malpractice cap for pain and suffering?

Morhaim: I favored the malpractice cap on pain and suffering and I think it should have been enacted. But I think we have to look at the bigger issue. Doctors are only human; we all make mistakes and things do go wrong. We need to figure out how to make the unfortunate patients as whole as possible. When a bad result is actually due to true negligence, we need to alter physician or health care provider behavior. These matters shouldn't always have to go through the legal system. It's slow, it's expensive, and it doesn't always serve everybody. What are we really trying to accomplish? If we are trying to help people out, we can do that much less expensively and with a lot less emotional wear and tear on all the parties.

Knodel: I want to get back to controlling health costs. Certainly as an emergency room physician, you do provide a large amount of care to the uninsured. On the other hand, people have argued that emergency room medicine is more expensive. I'd like to take a couple of the different components of the health care system and have you comment on things you feel might be equitable and effective cost control measures. Let's take the pharmaceutical industry first.

Morhaim: I've gone door to door a lot in my district and the high cost of drugs is a complaint that comes up a lot especially from senior citizens. They're on fixed incomes and medications that are prescribed are costing them \$80 or \$150 per month. We're going to have to find ways to cut the cost. Broader use of generic drugs and avoidance of multiple physicians prescribing for a patient without a real primary care provider are two potential steps. I see patients in the emergency room who are taking 10 to 12 drugs, no

all of which are necessary. Changing some of the FDA rules so that pharmaceutical companies can get their drugs to the market effectively without requiring huge marketing budgets should decrease costs. We must challenge the pharmaceutical companies to lower drug costs and increase drug availability. I'm also interested in "orphan" drugs, the medications that aren't profitable but may be very helpful for small groups of people. We're going to have to find a way to have those therapies available.

Knodell: I'd like to take the seniors' predicament in regard to pharmaceutical costs one step further. One part of the national health care plan has been to provide a medication program at no charge to seniors. That would be very popular with the senior lobby, which is very strong, but it could be extremely expensive. How do you feel about that?

Morhaim: The biggest challenge is going to be needs assessment. Some seniors are not well off and need help, while others are quite well off and don't need help. Right now, Medicare rules apply across the board, regardless of an individual's financial circumstances. That seems very egalitarian, but given our financial constraints, it's not really practical. We ought to target those seniors who have the need and meet their need.

Knodell: As a hospital staff member, are there any areas you might target for cost containment or cost reduction in the hospital system?

Morhaim: I think the biggest areas of cost containment and reduction within the hospital system are going to revolve around the multiple layers of external regulation. The public is entitled to regulations that are balanced and prevent excesses on one side or the other. During my years as a hospital-based physician, I've seen many layers of federal regulations and legislated rules that are very difficult to follow. I'll give you two quick examples. COBRA legislation came out at the federal level before the regulations were written. For months we had to wait to respond to a law for which there were no guidelines. We spent a lot of time that really wasn't very productive. Most recently in Maryland, there have been laws passed about patient care directives and who's responsible. Some of these laws are very, very complicated and I know at Franklin Square we struggled with how to implement them. Ultimately, we've got to strike more of a balance between appropriate scrutiny and regulation and redundancy and busy-work.

Knodell: The next several questions relate specifically to Maryland medicine. By most polls I've encountered, physicians want to be able to continue to treat their patients

and patients want the ability to choose their physician. What's your position on patient access legislation that allows physicians who meet a network's criteria to join that network?

Morhaim: You are referring here to "any willing provider" legislation, which I support. I think the ultimate goals of HMOs are laudable, that is, preventive care and managed use of resources. Unfortunately, some of the HMOs I deal with seem much more interested in the fiscal management of the patient than their health maintenance. I'll give you an anecdote from my personal experience, but it's generic and repeats over and over. I recently treated a child with recurrent otitis media. I couldn't help but notice cigarette packs in the parents' pockets, and I discussed with the parents the impact of secondhand smoking on recurring ear infections in children. They belonged to an HMO, but the effects of secondhand smoke had never been discussed. The HMO should be working with those parents and get them off cigarettes. It would be a great health care thing for them, would help their children, and presumably would decrease emergency room visits. But the HMO's goal was mainly to deny payment to us instead of really trying to manage the primary and preventive health care issue. Not all HMOs are the same and some are doing a better job than others. HMOs need to be reminded of what their primary directive is and focus on that.

Knodell: How do you feel about physicians having the right to negotiate prices with insurance companies, managed care entities, or hospitals? Do you feel that some of the regulations to encourage competition in many ways increase health costs?

Morhaim: I see many physicians trying to band together in the community and if there are regulations or laws that are preventing that, we should take a look at them. But my sense is that what's holding things back is that physicians are trying to understand the marketplace and their role in new organizations. We're being called on to behave in ways that are new and different, and we're not always comfortable or experienced.

Knodell: You mentioned that you very quickly settled on a career in emergency medicine. There have been suggestions that choice of specialties should be limited and the government might put quotas on how many specialists or primary care people there can be. Have you considered that type of regulation?

Morhaim: I don't think there ought to be legal quotas for how many medical specialists there can be. Society has numerous other mechanisms to regulate that. For ex-

ample, I think it's reasonable to increase reimbursement for cognitive as opposed to procedural services. That will have some effect without actually having to say there shall only be so many gastroenterologists or so many neurosurgeons. Of course, the flip side always comes up. If I need a neurosurgeon or a gastroenterologist, I really want to be able to have that specialist. And I'm not just speaking for me; that's the public demand. Enhanced prestige and reimbursement for people going into primary care fields would be the most direct and obvious way to encourage less specialization and still let individual physicians make their own specialty choices.

Knodell: You mentioned that your original political involvement was in nonmedical areas. What other issues do you think are important to the country and to Maryland at this time?

Morhaim: One issue that is really important is crime. I favor open parole hearings, honesty in sentencing, and restitution by criminals to their victims. I often take care of both parties from the same crime event, so I see the impact of both. I also favor strongly crime prevention programs and one of the quickest and most cost-effective ways to address crime is to fund drug treatment programs.

Education is clearly another very important political issue. I have children in the Baltimore County public school system. Early this year, my 16-year-old was in a class with 38 students for which there weren't enough textbooks. She wasn't getting homework because she couldn't bring a textbook home. The parents protested—I'm not sure the kids were delighted with that—but we did get enough text books in short order. People who are uneducated often are unemployed. Education is a priority, and I will work for excellence in this area. Without that, our children face an intellectually and economically bankrupt future.

The last issues I would like to speak to are the economy and the environment. Traditionally, these are often considered as polarizing; you can be for the environment or you can be for the economy, but you can't be for both. I completely disagree with that analysis; in fact, I think the two are inextricably linked. The better the economy, the more resources we'll have to fix the environment. And there are some ways to do that.

I have been active in recycling issues and let me give you one specific example. I started the Recycling/Environmental Task Force at Franklin Square Hospital. We found that by being environmentally conscious, we also reduced operational costs at the hospital by \$100,000 per year. The simplest change that I would like to share is two-sided

copying. Many physicians, nurses, and other providers go to hospital meetings where there are stacks of single-sided copies. We look at them for an hour, then throw them out. By requiring two-sided copying for those kinds of meetings, we lowered our copy paper bill by \$35,000 per year; mailings also were less expensive. It was a clear case where the economy and the environment overlapped.

In terms of recycling, we're collecting a lot of potentially recyclable material, but we don't yet have the industries to process and utilize them. I would favor economic development programs throughout the Baltimore metropolitan area, particularly where there are unused industrial sites. Give tax breaks to business entities that would use recyclables in the development of new products. This creates entry level jobs, and when people get those jobs, they go off the welfare rolls and onto the tax rolls. They develop a work ethic, the tax base goes up, and you have more money for education and other uses. Or, you can lower taxes.

That's what I mean when I say that all these things are interconnected. What I will do as a legislator is identify strategic entry points to stop these downward spirals. There's no quick fix. They're going to be complicated solutions, but we can identify some ways that we can facilitate and accelerate positive kinds of changes within our community.

Knodell: What have you done to prepare specifically for this campaign? It must be quite a stress on your profession and on your family.

Morhaim: I've had some experience with this before, being a campaign manager for other politicians and having successfully run for office myself. My youngest daughter is 10 years old and I have a 13-year-old and a 16-year-old. This was a family decision and my wife and children have been wonderfully supportive. They come with me to various political activities and when I go door to door. My colleagues at work have been extremely supportive, both in terms of financial contributions and in giving me some flexibility in my emergency department schedule. I've been very pleased with my fund-raising. So far, I've had good support from the medical community and from people from all walks of life. I have a solid campaign treasury, but I certainly would like to encourage anyone who'd like to contribute.

I meet voters three to four nights a week. I'm certainly straightforward about being a physician, but people in my community know me as citizen first. I've had three endorsements already. One is from TABCO (Teachers Association of Baltimore County), the second is from the Baltimore County firefighters, and the third is from the

metropolitan AFL-CIO. These endorsements are very good because they show the broad-based constituency that I appeal to.

Knodel: What hurdles do you have to get by to be elected?

Morhaim: Two incumbents are planning to run, but they only bring seven or eight precincts from their previous district to the 29 precincts in the new district. The incumbents don't have complete name recognition, and I saw this as a good entry opportunity.

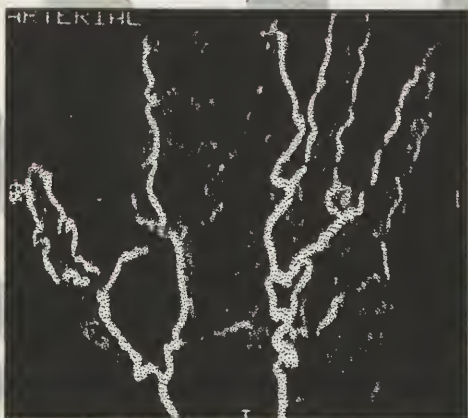
The primary election is Tuesday, September 13. I have to be one of the top three vote-getters in the Democratic primary to go into the general election in November. I think my chances are excellent. I have a good media team, a good campaign manager, a reasonable amount of fund-

ing, and I'm a tireless worker when it comes to going door to door. I go up to strangers every day in the emergency room and talk to them about things that are important to them; I have to establish rapport within just a few seconds. That same thing happens when I campaign. I meet strangers, establish rapport with them, and give them the opportunity to tell me what's on their minds. Other parts of the campaign are stressful, but meeting the public has been a real pleasure.

Knodel: How can those who want to know more about your views get in touch with you?

Morhaim: They can write to Citizens for Dan Morhaim, 8 Park Center Court #100, Owings Mills, MD 21117. Or they can call 410-363-3631 or 410-363-4561. ■

Upcoming issues of the *MMJ* will feature other candidates for political office. Inclusion of interviews with political candidates does not necessarily indicate support or endorsement. Any candidate wishing to be considered for an interview by the *MMJ* should contact the journal office at 410-539-0872 or 800-492-1056.



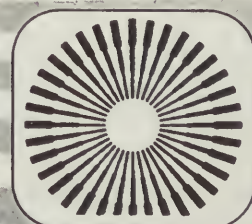
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Book Reviews

African-American Perspectives on Biomedical Ethics. Harley E. Flack and Edmund D. Pellegrino (eds). Washington, DC: Georgetown University Press. 1992. 203 pages. \$28.00

Before I read *African-American Perspectives on Biomedical Ethics* (PERSPECTIVES), I concluded that it was yet another attempt to describe non-existent American ethnic differences. While African-American philosophy may in many ways differ from the prevailing "Euro-Western" philosophy in the United States, biomedical ethics within the United States is universal. After reading the book, I am not sure that my conclusion has changed substantially, but I state it much more gingerly and with many qualifications. The reader must be prepared to listen to different points of view and engage in decision making. This is enlightening, but not easy reading.

PERSPECTIVES is a series of essays ranging from highly theoretical, scholarly discourse to plain talk philosophy that is even more compelling. This book will not necessarily provide you with the answers to questions that you may or may not have even considered. It will, however, engage your intellect and your own sense of moralism as you draw your own conclusions.

The book reflects presentations made at a 1990 conference cosponsored by Georgetown University, Howard University, Harvard University, and Glassboro State College, with support from the Kaiser Family Foundation. The conference emerged from ideas developed from a "Think Tank on Black Perspectives on Death and Dying," in 1987. The protagonists at this think tank felt that their finding of the existence of an "African-American perspective" on death and dying pointed up the need to expand the discussion to include the broad field of biomedical ethics. The questions discussed in this conference were:

- Is there an African-American perspective on biomedical ethics?

- What are the moral foundations of African and African-American cultures?
- What is the African-American concept of personhood?
- What are the African-American perspectives on wellness and the roles of healers and patients in African and African-American cultures?

In the keynote essay, Herman Branson, Ph.D., frames the issue of whether there is an African-American perspective. He nostalgically recalls mother Africa, the origin of man, and clearly documents different tribal views on death and dying within small countries in Africa. He also recalls a U.S. study that found that the vast majority of blacks carry mixed genes; not only African, but white European and Native American. Branson recalls a story told by Malcolm X about a young man who was feeling good about receiving his Ph.D. from Harvard. The young man said, "You know, Malcolm, I wonder what they call me?" Malcolm replied, "Nigger." Not surprisingly, Branson concludes that what is most important is for African-Americans to become "dedicated to trained intelligence—learning, knowing, moving, doing, presenting...for then honor will be done to the fact that most of our genes come from Africa."

William A. Banner categorically states that there is no ethnic perspective on biomedical ethics. He feels that there is a commonness in human existence and that when one focuses on a precise problem, there is "an extramental, extrapersonal order...to which the term perspective is inapplicable...." Banner concludes that "the universality of science and ethics is the answer to racism and...prejudice."

Annette Dula, on the other hand, argues that there is an African-American perspective that has its foundation in health experiences and in an unequal power

relationship between white health care systems and their African-American clients. She supports her conclusions by relating some of the well-known differences in access to health care and health outcomes between whites and blacks in the United States; by recalling some of the unconscionable dictates of the American Eugenics Society and improper and illegal sterilization of black women; and by recalling the shameful Tuskegee experiments. Dula concludes that the reality of experience for African-Americans has dictated a perspective that must be more clearly and forcefully articulated.

Jorge L.A. Garcia engages in a scholarly consideration of Banner's conclusions, discussing cultural relativism and normative issues. He supports Banner's thesis that ethics involves an extramental order, but rejects the concept that perspective has no appropriate place, concluding that indeed even ethnic perspective is appropriate. Garcia expounds on a number of philosophical principles and uses numerous historical examples to support the basis and reality of an African-American perspective. He indicates clearly, however, that one should not expect a single perspective.

Kwasi Wiredu provides insight into the morality and culture of the Akans of

Ghana. He also describes their conception of "personhood," which is a state of achievement that requires but goes beyond humanism. Personhood requires at the very least marriage and procreation, but also a track record of responsibility and achievement. Therefore, children cannot achieve personhood and funerals are not observed upon their death. If one's actions do not allow becoming a "person," psychological or medical reasons may be sought as explanations. Thus, the reader begins to understand a basis for a unique perspective on biomedical ethics, as well as on death and dying. While enlightening, Wiredu raised serious questions for me as to the reality of a single African or African-American perspective, considering the cultural differences and moral doctrines of different nations and tribes in Africa.

Leonard Harris revisits the African-American approach to health care against the background of struggling against dominant authorities within the health system. Using two bold metaphoric descriptions, Harris provides a poignant indictment of the *historically* well-meaning, but clearly unethical (in my view) approach to biomedical ethics afforded black people in our country, as well as the continued medical indignities of racism. Consider-

ing a unique perspective, Harris states, "If we are not sufficiently aggressive in instituting cultural change to influence dietary habits as a way of curtailing diabetes, one reason may be that...African-Americans shy away from being thoroughly self-critical since they are already subject to so many demeaning criticisms."

The four questions alluded to earlier are in large part answered in this book. The reader ultimately will have to decide on the reality of the African-American perspective. Certainly there is an African-American viewpoint; certainly there are historical and cultural factors that influence the provision of health care to African-Americans in this country; certainly there is a lack of understanding of and appropriate sensitivity toward the "personhood," needs, and cures for African-Americans. Should there be an African-American perspective on biomedical ethics?

Certainly not.

DONALD E. WILSON, M.D., M.A.C.P.
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Medicine ■

A Clinical Moment with Endocrinology and Metabolism

Hypertension and Hypokalemia

Dear Doctor:
A 45-year-old white woman came to my office for a general physical examination. Although she had no complaints, her blood pressure (seated) was 150/100 mm Hg. Routine laboratory testing showed her potassium level was 3.1 mEq/L and her sodium level was 145 mEq/L. All other values were within normal limits. I want to do appropriate tests to rule out an adrenal tumor. What should I do next?

Evaluating the combination of hypertension and hypokalemia is both important and complex. The patient's low potassium level strongly suggests an endocrine cause of the hypertension. Causes of the hypertension/hypokalemia combination include

- pheochromocytoma;
- severe glucocorticoid excess, such as occurs in ectopic ACTH syndrome or adrenocortical cancer, and rarely in Cushing's syndrome;
- hyperaldosteronism, which may be primary, secondary, or glucocorticoid suppressible.

Given the absence of other clinical findings, it is unlikely that your patient's metabolic problem is pheochromocytoma or excess glucocorticoid. Nevertheless, 24-hour urine collections to measure metanephrines and urinary-free cortisol will rule out these possibilities.

More likely to reveal positive results are tests of aldosterone secretion. In primary aldosteronism, excessive aldosterone is secreted by the adrenal cortex, suppressing renin production by the kidney. In secondary hyperaldosteronism, as in renal artery stenosis, aldosterone is secreted in response to elevated renin (and angiotensin) levels. As a result, the relationship between the two hormones is essential to the diagnosis. Although random measurement of the levels of aldosterone and its companion, renin, are of little value, two relatively simple tests will evaluate both renin and aldosterone secretion.

The captopril stimulation test is the simplest to perform. The patient's blood pressure and aldosterone and renin

levels are measured, following which the seated patient is given an oral dose (usually 25 to 50 mg) of captopril. Blood pressure is followed closely for 90 minutes; a good response suggests a high renin state, but is not diagnostic. Renin and aldosterone levels are obtained again and compared with baseline values. Since captopril blocks production of angiotensin II from angiotensin I, if aldosterone is angiotensin (renin)-dependent, the normal response is an aldosterone level lower than baseline. If renin is not suppressed by excess aldosterone, it will rise in response to inhibited production of angiotensin II, which normally inhibits renin secretion. In low renin hypertension and primary aldosteronism, the renin level will not rise; in renal artery stenosis, the renin level rises to greater than 5 to 6 ng/ml/hr. The captopril stimulation test thus gives clues to excessive levels of both aldosterone and renin.

If renin is hyperresponsive, the next step is to evaluate the renal arteries. If the aldosterone level is elevated and does not fall and renin is suppressed, a second diagnostic step is required. Nonsuppressibility of aldosterone must be demonstrated; the simplest confirmatory test is a two-liter infusion of normal saline over four hours. The patient's baseline aldosterone level is then compared with the postinfusion level. If the latter is greater than 10 ng/dL, the diagnosis of primary hyperaldosteronism is confirmed.

The next step in the evaluation would be use of localization procedures to differentiate between a single adenoma and bilateral hyperplasia. In rare circumstances, it also may be necessary to rule out glucocorticoid-suppressible mineralocorticoid excess, which is caused by abnormal metabolism of cortisol rather than excess secretion of aldosterone.

In any case, it is essential to screen for hypokalemia and do the diagnostic evaluation before initiating medications, which may confound testing. The entire evaluation can be done in one day, thereby only briefly postponing therapy.

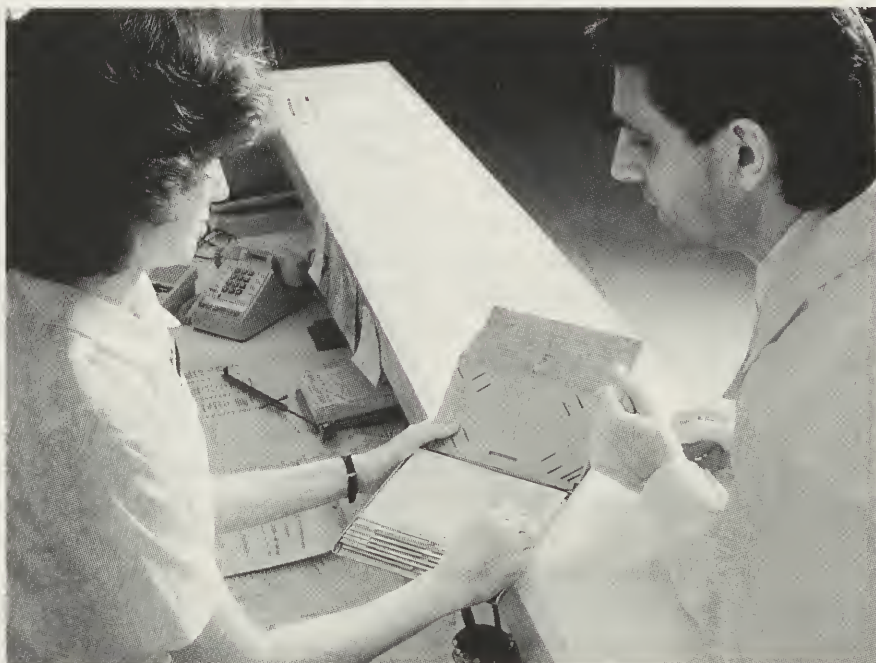
JAMES H. MERSEY, M.D.
Editor ■

TO OUR READERS



A new format for "A Clinical Moment with Diabetes" has been created. Content material will now include endocrinology and metabolism, as well as diabetes. Questions will be from physician to consultant. We hope this new format will allow for more useful information for physician readers. It will also provide a forum for responding to readers' questions. If you have a particular question, please forward it to the department editor: James Mersey, M.D., Suite 411, 6565 North Charles St., Baltimore, MD 21204.

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Members in the News



RANDY S. ELLIS, M.D., F.A.C.E.P., F.A.C.P.E., recently was elected to serve on the board of directors of the American College of Physician Executives. Dr. Ellis is director of the emergency department at Washington County Hospital in Hagerstown, Maryland, and

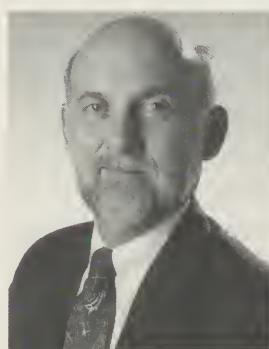
regional medical director of EMSA Limited Partnership. A past president of the Washington County Medical Society, Dr. Ellis is a member of numerous professional societies, including the American Medical Association, Southern Medical Association, National Association of EMS physicians, and AHA Society for Ambulatory Care Professionals. She was the 1992-1993 chair of the Women in Medicine Committee for the Medical and Chirurgical Faculty of Maryland and has served on Med Chi's EMS committee since 1987. In 1993, she received the President's Award for Excellence from the Washington County Hospital Association and in 1989, the Distinguished Service Award from the Maryland Institute for Emergency Medical Services Systems. Dr. Ellis received her medical degree from the University of North Carolina, Chapel Hill, and completed basic surgery and neurosurgical residencies at the University of Chicago Hospitals and Clinics. She is board certified by the American Board of Medical Management and the American Board of Emergency Medicine, for which she is currently a member of the board of examiners.



RONALD H. FISHBEIN, M.D., has been named chairperson of the Scientific Council of the Maryland Science Center. He also recently was awarded the Premier Physician Award of the Maryland Chapter of the Crohn's and Colitis Foundation of America. He has been

chairperson of the Maryland chapter since 1990. Dr. Fishbein, a surgeon affiliated with The Johns Hopkins Hospital, Sinai Hospital of Baltimore, and Greater Baltimore Medical Center, is a former dean of admissions at The Johns Hopkins University School of Medicine. He has been a member of the board of directors of

the Baltimore City Medical Society Foundation since 1975. He is chairperson of Med Chi's library and history committee as well as its ad hoc bicentennial committee. Dr. Fishbein received his undergraduate degree from Lafayette College in Easton, Pennsylvania, and his medical degree from Yale University School of Medicine. He completed a residency in surgery at Baltimore City Hospitals and was a surgical fellow at Hopkins. Dr. Fishbein, a diplomate of the American Board of Surgery, is a member of the American College of Surgeons and the American Heart Association.



JAMES D. LEVY, M.D., M.B.A., F.A.C.P., recently was named medical director of corporate care and chief physician in the division of occupational and environmental medicine at Mercy Medical Center in Baltimore. A native of Wichita, Kansas, Dr. Levy received his medical degree

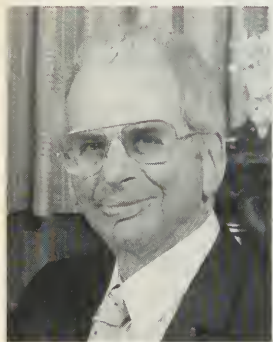
from the University of Oregon School of Medicine in Portland, and his master's degree in business administration from Loyola College in Baltimore. He completed his internship and residency at Walter Reed General Hospital in Washington, DC, and was a fellow in the research training program in clinical immunology at Walter Reed Army Institute of Research. Dr. Levy is board certified in occupational medicine and preventive medicine and is a diplomate of the American Board of Internal Medicine and the American Board of Allergy and Immunology. He is a member of several medical organizations, including the American College of Occupational and Environmental Medicine, American College of Physician Executives, and American Medical Association.



ARNALL PATZ, M.D., SC.D., professor and director emeritus of the Wilmer Eye Institute at The Johns Hopkins Hospital, was awarded the first Helen Keller Prize for Vision Research from the Helen Keller Eye Research Foundation for his achievements in vision research. Dr. Patz is noted for

his contributions to the discovery of the cause of

retinopathy of prematurity and for his pioneering work with the argon laser and laser photocoagulation. He is national co-chairperson of the Diabetes 2000 project of the American Academy of Ophthalmology. He is a past president of the Maryland Society for the Prevention of Blindness and a member of the board of directors of the Maryland Eye Bank. He is also chairperson of the ad hoc Committee on Diabetic Retinopathy Education of the National Society for the Prevention of Blindness. A prolific author, Dr. Patz has published over 200 scientific papers and is the recipient of numerous awards, including the Albert Lasker Research Award. Dr. Patz, a 40-year member of the Medical and Chirurgical Faculty of Maryland, received his undergraduate degree from Emory University, in Atlanta, Georgia, and his medical degree from Emory University School of Medicine.



IRVING J. TAYLOR, M.D., L.F.A.P.A., was honored by the University of Maryland School of Medicine, his alma mater, with the dedication of the Dr. Irving J. Taylor '43M Learning Resource Center. Chairman of the board of Taylor Manor Hospital in Ellicott City, Maryland, Dr.

Taylor is a psychiatrist who has worked for decades to destigmatize mental illness. He was the first clinical researcher in the United States to use an antipsychotic drug for schizophrenia in a private hospital milieu and over the years has implemented a number of specialized treatment protocols for distinct patient groups, including children and adolescents, clergy, and compulsive gamblers. A 50-year member of the Medical and Chirurgical Faculty of Maryland, Dr. Taylor received his undergraduate degree from The Johns Hopkins University. He completed his internship at Baltimore City Hospitals, his medical residency at West Baltimore General Hospital, and psychiatric residencies at the Veterans Administration Hospital in Perry Point, Maryland, and Spring Grove State Hospital, in Catonsville, Maryland. Board certified in psychiatry and neurology, Dr. Taylor served on the mental health advisory boards of several Maryland governors and is an assistant professor of psychiatry The Johns Hopkins Hospital.



MICHAEL A. WILLIAMS, M.D., a neurologist and specialist in critical care medicine, was elected in June to the AMA Council on Scientific Affairs (CSA). As a member of the CSA, Dr. Williams' responsibilities include proposing and evaluating activities that might be

undertaken by the AMA as major scientific projects and advising the AMA on promising scientific developments in medicine and biomedical research that warrant public attention. Dr. Williams is an assistant professor in the department of neurology and has a joint appointment in the departments of anesthesiology/critical care medicine and neurosurgery at The Johns Hopkins University School of Medicine. He is also director of the clinical neurocirculatory laboratory at Hopkins. In 1990, he was awarded the Charles A. Dana fellowship in neurosciences critical care and in 1989, he was awarded the Eleanor Naylor Dana fellowship in critical care. Certified by the National Board of Medical Examiners and the American Board of Psychiatry and Neurology, Dr. Williams received his medical degree in 1985 from Indiana University School of Medicine. He is a member of the American Medical Association, American Academy of Neurology, Society of Critical Care Medicine, and Ethics Committee and Consultation Service at The Johns Hopkins Hospital. Dr. Williams has published several papers and book chapters on neurology and related topics.

American Medical Association Education and Research Foundation

As we open the books on the new year, 1994-1995, the Med Chi Alliance urges all members of Maryland's medical family to increase support of one of the most important philanthropic efforts of organized medicine—the American Medical Association Education and Research Foundation (AMA-ERF). Unlike many of the worthy causes to which we contribute, not one penny of any donation to AMA-ERF is withheld for administrative purposes (e.g., salaries, postage). In addition, all contributions of \$10 or more are acknowledged by an official receipt from AMA-ERF.

History in brief

In the early 1950s, when American medical schools were operating at a deficit of approximately \$10 million per year, the AMA board of trustees established the American Medical Education Foundation (AMEF). It was organized specifically to raise funds from the medical community to support medical education.

In 1953, when the plight of the nation's medical schools reached the crisis stage, the AMA sought help from the national auxiliary (now the alliance). Auxiliary members responded enthusiastically, considering it their obligation to participate in a program that, beginning at medical school level, could improve health and quality of life. AMA-ERF committees were formed in every organized state auxiliary and, in time, in every county auxiliary. Realizing that contributions alone would be inadequate, local auxiliaries nationwide, with the help of the national auxiliary, began sponsoring fund-raisers. As a result, contributions from physicians and their spouses surpassed the most optimistic predictions. Grants from the foundation have averaged over \$1 million per year since the auxiliaries joined the effort.

Donation categories

Monies donated to AMA-ERF are used in several ways, and donors may specify how they wish their contributions to be distributed. Today, AMA-ERF has several funds.

The Medical School Excellence Fund (MSEF) is the oldest and largest. Over the years, it has given approximately \$49 million to medical schools in unrestricted

funds that have been used to support programs for women and minority medical students; pay for educational materials; and fund student activities, guest lectures, research programs, and student attendance at national meetings and conferences.

The Medical Student Assistance Fund (MSAF), created in 1983, has raised more than \$500,000 each year. Until 1993, contributions were used for scholarships, grants, and loans. (In 1993, seven local students were awarded scholarships through AMA-ERF funding). In 1994, all U.S. medical schools that receive AMA-ERF funds were asked to establish a loan program that would be funded by MSAF contributions and a grant from the foundation. The goal was to increase the visibility of AMA-ERF at medical schools and to add longevity to the funds raised by providing student loans, which are a renewable resource that, once repaid, will help the next generation of medical students.

Although the MSEF and the MSAF are the first priorities of the Med Chi alliance, there are two additional areas to which donors may designate contributions. First is the Development Fund, which is used at the discretion of the AMA-ERF board of directors to support pilot and experimental health and medical programs. Grants in one year, for example, supported student research forums, work on alcoholism, and studies of the effects on children of drugs taken by mothers during pregnancy. Second is the Categorical Fund, which provides support for specific research areas designated by donors (neuromuscular diseases, metabolic and endocrine diseases, neoplastic diseases, cardiovascular and pulmonary diseases, and arthritis and rheumatism).

Medical school grants

AMA-ERF collects contributions from physicians and alliances/auxiliaries during the calendar year and distributes them each March. Two checks are prepared for each medical school, one from the MSEF and one from the MSAF. The checks are sent to the state medical society or association for presentation, usually at annual meeting time, to the medical school deans. In 1994, The Johns Hopkins University School of Medicine received

\$10,743.41 in MSEF funds and \$7,520.00 in MSAF funds, and the University of Maryland School of Medicine received \$16,904.97 in MSEF funds and \$10,318.75 in MSAF funds.

Med Chi alliance role

AMA-ERF committees have sponsored a variety of ingenious fund-raising activities, including art auctions, raffles, and dinner-dances. Med Chi members here in Maryland even participated in a talent show at one of the semiannual meetings (that was a huge success!). Through Med Chi's generosity, the alliance has had boutique space at the annual and semiannual meetings for a number of years. Our most lucrative project has been the national Holiday Sharing Card, which has been promoted by several of our county components. In 1993, seven county components and the state board raised \$16,000 for AMA-ERF. Our Basket Auction alone raised \$1,650 as of the 1994 annual meeting.

The Med Chi alliance will continue to seek new avenues for raising funds. Government funding of our medical schools is a historic item; if we do not, will not, or cannot lend some measure of financial aid, how can we expect our medical schools to continue to achieve medical excellence? Individually and collectively, we can help make it happen.

ADRIANA ZARBIN

Med Chi Alliance president

Elizabeth A. Linhardt, Maryland AMA-ERF chairperson, contributed to this article. ■

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IF YOU ARE PREGNANT OR THINKING ABOUT GETTING PREGNANT

Some pregnant women may be at risk of catching communicable diseases that could infect their baby before it is born or at the time of birth. Some of these infections are very common—at home, in the community, in child care centers and schools. Some are rare. Some are spread through the air, some by direct contact with infected body fluids, while others are sexually transmitted or require close contact for a long time. While sexually transmitted diseases (STDs) are common, they are not an occupational risk.

Here is a list of communicable diseases to look out for during pregnancy:

- Chickenpox
- Cytomegalovirus infection (CMV)
- Fifth Disease (Parvovirus B19)
- Hepatitis B
- Measles
- Mumps
- Rubella
- Sexually Transmitted Diseases (STDs)
 - Chlamydia
 - Gonorrhea
 - Hepatitis B
 - Herpes
 - Human immunodeficiency virus(HIV)
 - Syphilis
- Toxoplasmosis
- Certain other bacterial or viral diseases

School and child care employees, and students who are pregnant or who are thinking about getting pregnant should be aware of these diseases. They can then check with their doctors before and/or after they get exposed. Blood tests may be needed to see if the woman could catch these diseases. Other women may need vaccines or treatment for protection.

Pregnant women should check with their doctors if they think they have been in contact with any of the diseases listed above or if they have symptoms of these diseases. Each exposed person needs to be individually evaluated. All pregnant women do not routinely need to be excluded from settings where diseases are occurring since the risk to the pregnant woman will depend on the type of disease, the way the disease is spread, and whether the woman is already immune to the disease.

AIDS AND HIV FACT SHEET

AIDS is caused by a virus called HIV

"AIDS" stands for acquired immunodeficiency syndrome. The AIDS virus, HIV (human immunodeficiency virus), infects certain cells of the immune system called T-helper cells. HIV can kill these cells, and then a person can develop other serious diseases.

People at highest risk of AIDS and HIV infection are:

- Drug users who share needles
- Men who have sex with other men
- Babies born to mothers who have HIV
- People who have hemophilia or who got blood transfusions infected with HIV
- Anyone who has sex with anyone who has or is at risk of AIDS or HIV infection

HIV is in blood and other body fluids

The virus is in the blood, semen, menstrual blood, vaginal secretions, and breast milk, and rarely in saliva and tears. The virus can be there even if the person has no symptoms of AIDS or HIV infection. People who are infected with HIV will carry the virus for the rest of their lives.

AIDS and HIV is spread by exposure to blood and body fluids

HIV can be spread during sex, by sharing dirty needles to inject drugs, or from mother to baby (before or during birth, or by breast milk). The AIDS virus is rarely spread by getting stuck by a needle, or by getting blood or other infected body fluids onto a mucous membrane (mouth or eyes) or onto broken skin. The virus is **not** spread by casual contact like living in the same household, or working with a person who carries HIV.

Symptoms to look for:

- Fever
- Weight loss
- Swollen lymph glands in the neck, under arms, or groin
- White patches in the mouth (thrush)
- Certain cancers (Kaposi's sarcoma, certain lymphomas)
- Infections (Pneumocystis pneumonia, certain types of meningitis, toxoplasmosis, certain blood infections, TB, etc.)

A blood test may tell if you have HIV infection or AIDS

You can get a blood test at your doctor's office or at Counseling and Testing Sites throughout Maryland. Call your local health department or the AIDS Hotline (1-800-638-6252) for information.

There is treatment for people with HIV infection and AIDS

Many drugs are available to treat the infections and cancers associated with AIDS. There are also drugs available for people with HIV infection that prevent them from getting sicker.

HIV and AIDS are preventable:

- Avoid infection by being monogamous, that is, only have sex with one person who only has sex with you. Avoid sex with a person known or suspected to have AIDS or HIV.
- Avoid unprotected sex—use latex condoms and spermicides that contain nonoxynol-9.
- People who use IV drugs should try to get off drugs. If they can't they should always use new needles or should clean needles and works with bleach and water.
- People with HIV or AIDS should clean up anything that gets blood or body fluids on it by using a mixture of one part chlorine bleach and nine parts of water.
- People with HIV or AIDS should tell their doctors, dentists, and their sex partners.
- Health care workers and dental care workers should use "universal precautions," that is, always use gloves and other protection to prevent getting exposed to any blood and body fluids, and prevent getting stuck or injured by needles or sharp objects.
- Women who plan a pregnancy should get tested to be sure they won't pass the AIDS virus to the baby.

CHICKENPOX FACT SHEET

Chickenpox is caused by a virus called varicella-zoster

Almost everyone gets chickenpox when they are young. About 75% of people have had chickenpox by age 15 and 90% by their early 20's. The illness is more serious in newborn babies and in adults.

The virus is in the nose and throat, and in the skin rash (blisters)

It spreads when the next child or adult comes in contact with the virus, either directly by touching, or through the air. Chickenpox virus can be spread for about 1-2 days before rash to 5 days after the start of the rash or until the blisters are dry. Chickenpox is more common in the winter and spring.

Signs to look for:

- Fever
- Tiredness
- Itchy rash with small blisters that dry up and form scabs

Symptoms start about 2 weeks after exposure (range 10-21 days).

Some people are at risk of complications from chickenpox:

- A premature baby (if born to a mother who hasn't had chickenpox before)
- A newborn baby whose mother has onset of chickenpox from 5 days before delivery to 2 days after delivery of the baby
- People with leukemia
- People with immune suppression or immunodeficiency
- Pregnant women who haven't had chickenpox before (their unborn baby may be affected)
- Children and teenagers who take aspirin when they have chickenpox are at risk of Reye's syndrome

A shot or medication may help

Some newborn babies, any immunodeficient child, and any pregnant woman or person over 14 years old who hasn't had chickenpox before may need a shot of VZIG (varicella-zoster immune globulin) to try to prevent chickenpox after they have been exposed. VZIG needs to be given as soon as possible but within 96 hours after exposure to chickenpox. No chickenpox vaccine is currently licensed in the U.S. for general use. Acyclovir is a drug that is now given to some people within the first day after rash onset to make the symptoms of chickenpox milder. Check with your doctor.

To help prevent the spread:

Stay home away from others until the blisters are dry and crusted.

A pregnant woman should check with her doctor if she has been exposed

Pregnant women should check with their doctors if they have been in contact with a person who has chickenpox or if they have symptoms of chickenpox. **Each exposed person needs to be individually evaluated.** Pregnant women do not routinely need to be excluded from settings where chickenpox is occurring or from being in contact with a person who has chickenpox unless the woman hasn't had chickenpox before. The risk to the pregnant woman will depend on whether the woman is already immune to chickenpox. If a pregnant woman hasn't had chickenpox before, the doctor may recommend VZIG after the exposure.

CHLAMYDIA FACT SHEET

Chlamydia is an infection caused by a bacterium

Chlamydia trachomatis is the bacterium (germ) that causes chlamydia.

Chlamydia is spread by sexual contact and from mother to baby

The bacterium is found in infected body fluids from the penis or vagina and spread by direct sexual contact (touching or rubbing). Babies can develop eye and ear infections as well as pneumonia. Sometimes this infection becomes so serious in babies that they may die.

Symptoms to look for:

- Discharge from the penis, vagina, or rectum
- Bad cramping or severe pain in the pelvic area (pelvic inflammatory disease or PID)
- Burning or itching around the opening of the penis
- Pain in the testicles
- Pain when urinating

The first symptoms may start 7 to 30 days after contact with an infected person. Many men and women can have chlamydia and spread it without having any symptoms at all. If the infection is not treated, chlamydia can damage reproductive organs, sometimes causing sterility.

Chlamydia can be treated with antibiotics

Since the symptoms of chlamydia and gonorrhea are similar and both diseases can occur at the same time, everyone treated for gonorrhea should also be treated for chlamydia.

Chlamydia is preventable

- Avoid infection by being monogamous, that is, only have sex with one person who only has sex with you
- Avoid unprotected sex — use condoms
- Know the signs of chlamydia infection

If you think you or your partner(s) have chlamydia or any other STD, see your doctor and don't have sex

If you have chlamydia, tell your partners so that they can be treated

Don't have sex until both you and your partner have finished treatment.

CONJUNCTIVITIS ("PINK EYE") FACT SHEET

Conjunctivitis is an infection of the eyes commonly known as "pink eye"

It is most often caused by a virus but can also be caused by bacteria.

Symptoms the eye include:

- Redness, irritation
- Itchiness; may produce lots of tears and discharge (clear or yellow)
- Discharge may make the eyelids and eyelashes stick together, especially in the morning

The tears or the discharges from the eye are infectious

People can get conjunctivitis by coming into contact with the tears or discharges from the eyes of an infected person and then touching their own eyes.

Anyone can catch conjunctivitis

Preschoolers and school-age children get it most often.

Conjunctivitis is a mild illness

Viral conjunctivitis will go away by itself in one to three weeks. Yellow pus may be a sign of infection by bacteria in addition to a viral infection.

An eye medication is available

Doctors may give an antibiotic eye medication in case the cause is bacterial. There is no treatment for common viral conjunctivitis.

People with conjunctivitis should:

- Wash their hands after touching or wiping their eyes
- Avoid touching other people's eyes
- Throw away or carefully wash items that touch their eyes
- Do not share eye make up or other items used on their eyes (for example, towels, or tissues)
- See a doctor in case you need medication

CYTOMEGALOVIRUS (CMV) FACT SHEET

Cytomegalovirus (CMV) is caused by a common virus

CMV is a virus that is harmless to most people. CMV is a member of the herpes group of viruses.

Most people catch CMV at some time in their lives

Most adults and children who catch CMV have no symptoms and are not harmed by the virus. Symptoms some people may get are fever, sore throat, fatigue, and swollen glands.

CMV is usually spread through close person-to-person contact

Close contact includes kissing and getting saliva or urine on your hands and then touching your nose or mouth. A pregnant woman who is infected may also pass the virus to her developing baby. A baby may also be infected during birth, as a newborn, and through breast feeding. CMV may be found in body secretions, such as urine, saliva, feces, blood and blood products, breast milk, semen and cervical secretions. CMV can be in these secretions for months to years after the infection. CMV can be spread through blood transfusion and organ transplantation.

Three groups of people are at higher risk of problems from CMV:

- Unborn children born to women who catch CMV for the first time during pregnancy. About 7-10% of these babies will have symptoms at birth or will develop disabilities including mental retardation, small head size, hearing loss, and delays in development.
- People on certain drugs or medicines such as chemotherapy or organ transplant medicines. If infected, these people may get a more serious illness.
- People who can't fight infection (those with immune deficiency diseases, such as AIDS) may also develop serious illness.

Laboratory tests can look for the virus or for antibodies to the virus

These tests can be ordered to diagnose CMV in a person with symptoms. Antibodies can be looked for to see if the person was infected with CMV in the past.

Exclusion of children with CMV is not necessary

Children known to have CMV should not be excluded from school or child care facilities. This is because CMV is very common and there are many other healthy children who may be shedding the virus too—so, good personal hygiene is needed—all the time.

Prevent infection with good personal hygiene

CMV is widespread in the community. The best way to prevent or lessen the chance of infection is by being very clean. Always wash your hands after diapering and handling any baby at home or at work since urine and saliva are important sources of CMV.

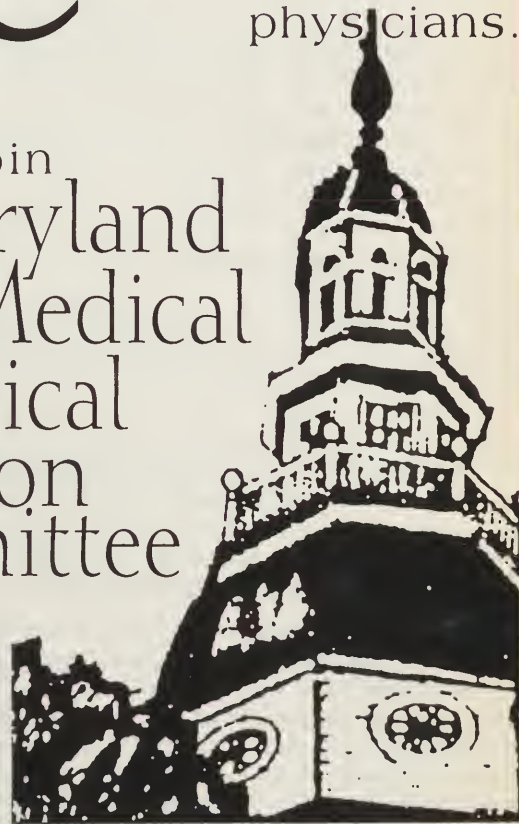
Pregnant women should check with their doctors

Pregnant women and women considering pregnancy should realize that they may be at risk of CMV from contact with saliva or urine of family members, others in the community, and in occupational settings. A pregnant woman or a woman who is considering pregnancy should talk to her doctor if she cares for infants or young children, or handles urine or saliva in any home or occupational setting. The doctor may want to check her blood to see if she is susceptible. Current public health practice indicates that pregnant women do not need to be excluded from such situations, but they should know about the possible risks at home and at work and should know that good personal hygiene is the most important preventive measure. In situations of **good hygiene**, even a woman who is susceptible to CMV is at very low risk of catching CMV.

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Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

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The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

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All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

References—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50-4.

• **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

• **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of

corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
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- ☐ Everything double-spaced.
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of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

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The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

- | | |
|---|---------------------------------------|
| Johns Hopkins third annual update on obstetric anesthesia plus an optional fiberoptic airway management workshop. 12 Cat 1 AMA/PRA credits. Fee: \$275/physicians; \$75/residents and fellows; one-day fees available. | Aug. 13-14 |
| Update on ocular infectious diseases. 8 Cat 1 AMA credits. | Sept. 1 |
| 23rd Annual diagnostic ultrasound in obstetrics and gynecology and abdomen, at the Stouffer Harborplace Hotel, Baltimore, MD. 16.5 Cat 1 AMA credits. | Sept. 9-11 |
| Tuberculosis in the 1990s: Epidemiology, treatment and control. 8 Cat 1 AMA credits. | Sept. 12 |
| AIDS: Challenges for the patient/challenges for the nurse, at the Sheraton Baltimore, North, Towson, MD. 8 Cat 1 AMA credits. | Sept. 13 |
| Ophthalmology for the pediatrician. Cat 1 AMA credits available. Fee: \$125/physicians; \$95/residents, fellows and allied health professionals. | Sept. 16 |
| Airway management: Hands-on workshops, case management colloquia, and difficult airway/intubation alert. Cat 1 AMA/PRA credits available. Fee: \$650. | Sept. 23-25 |
| Pediatrics for practitioner update '94. 14 Cat 1 AMA credits. Fee: \$290/physicians; \$190/residents*, retired physicians, allied health professionals, fellows* (with letter). | Sept. 29-30 |
| Hands-on flexible sigmoidoscopy course. Cat 1 AMA credits available. Fee: \$550/physicians, \$400/residents, fellows. | Oct. 8 |
| 20th anniversary: Annual topics in gastroenterology and liver disease. Cat 1 AMA/PRA credits available. Fee: \$495/physicians; \$250/residents and fellows (with letter from department chairperson verifying status). | Oct. 5-7 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA/PRA credits available. Fee: \$500/lectures; \$400/each additional lab; \$200/lectures for fellows and allied health professionals. | Oct. 24-26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250/presymposium workshop; \$450/symposium; \$250/residents and full-time students. | Oct. 27-30 |
| Update on rhinosinusitis for the practitioner. 8.5 Cat 1 AMA credits. \$190/physicians, \$95/residents, fellows and allied health professionals. | Oct. 28 |
| Advanced pediatric life support courses. 20 Cat 1 AMA credits. Fee: \$525. | Oct. 31-Nov. 2; June 12-14 |
| The 100th anniversary of blastomycosis/fungal infections in immunocompromised hosts. 10 Cat 1 AMA credits. | Nov. 12-13 |
| Advances in pediatric nutrition, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: \$200/physicians and allied health professionals; \$150/residents and fellows. | Nov. 14-16 |
| Memory and reality: Reconciliation. Scientific, clinical and legal issues of false memory syndrome, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: Postmarked before Oct. 1: \$300/professionals; \$125/families (includes 2 family members), postmarked after Oct. 1: \$400/professionals; \$275/families (includes 2 family members). | Dec. 9-11 |

The Johns Hopkins Medical Institutions (continued)

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Johns Hopkins sports medicine grand rounds.** Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- | | |
|--|-------------------------|
| Endocrinology update for the practicing physician 1994 , at Harrisons Pier 5, Baltimore, MD. 10 Cat 1 AMA credits. Fee: \$175/physicians; \$100/residents and fellows. Info: Dorothy Taylor 410-328-2515. | Oct. 7-8 |
| R. Adams Cowley 16th annual national trauma symposium , at the Hyatt Regency, in Baltimore, MD. Info: 410-328-2399. | Nov. 16-20, 1994 |

Miscellaneous meetings

- | | |
|--|----------------|
| Trials and Deliberations in Medicine. Attendants receive a 5% discount on 1995 Med Mutual renewal premiums and 2 Cat 1 AMA/PRA credits. Fee: \$40.00. Info: Toni Davis or Natalie Harper, 410-785-0050. | |
| Ramada Inn, Hagerstown | Aug. 4 |
| Medical Mutual, Hunt Valley | Aug. 9 |
| Med Chi, Baltimore | Aug. 16 |
| Kent/Queen Anne's Hosp., Chestertown | Aug. 18 |
| Shady Grove Hospital, Rockville | Aug. 23 |
| Columbia Conference Center, Columbia | Aug. 24 |
| Liberty Medical Center, Baltimore | Aug. 25 |
| Medical Mutual, Hunt Valley | Aug. 30 |
| Patuxent Medical Group, Columbia | Sept. 1 |
| Harford Memorial, Havre de Grace | Sept. 6 |
| Medical Mutual, Hunt Valley | Sept. 7 |

Miscellaneous meetings (continued)

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| Anne Arundel Med. Ctr., Annapolis | Sept. 8 |
| Medical Mutual, Hunt Valley | Sept. 12 |
| Doctor's Comm. Hosp., Lanham | Sept. 13 |
| Holy Cross Hosp., Silver Spring | Sept. 20 |
| Medical Mutual, Hunt Valley | Sept. 21 |
| Frederick Memorial, Frederick | Sept. 22 |
| Annual meeting of the Bollvian Medical Society , sponsored by the George Washington University Medical Center, in Arlington, VA. Info: Todd Belfield, 202-994-4285. | Aug. 4-7 |
| Women's health research topic , sponsored by the Baltimore City Medical Society at the Montebello Rehabilitation Hospital. 1 Cat 1 AMA Credit, Fee: Free. Info: 410-625-0022. | Sept. 1 |
| Diabetic retinopathy: A comprehensive review and update , sponsored by The American Diabetes Assoc. and The Retina Institute of MD, at the Stouffer Harborplace Hotel, Baltimore. 7.5 Cat 1 AMA Credits. Fee: \$275/physicians, \$100/fellows, residents, and allied health professionals. Info: 410-337-4500. | Sept. 23 |
| Topics in clinical rheumatology: An arthritis update for internists, family practitioners, orthopedists, rheumatologists and other primary care providers , at the Stouffer Harborplace Hotel, Baltimore, MD. \$50 for Cat 1 AMA credits, \$30 for AAFP credits. Info: Karen Krug 410-602-0160. | Sept. 30 |
| Hematology board review course , sponsored by the George Washington University Medical Center, at the Ritz-Carlton, in Pentagon City, VA. Info: Maria Gorrick, 202-994-4285. | Oct. |
| Network approach to provision of health care , sponsored by the Baltimore City Medical Society at the Good Samaritan Hospital. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. | Oct. 6 |
| Psycho-economics: clinical psychiatry and health care reform in the 1990s , sponsored by the American Psychiatric Association, in Baltimore, MD. 34 Cat 1 AMA/PRA credits. Info: 202-682-6174. | Oct. 8-12 |
| Second annual gynecology CME course , at the Plaza Hotel in NY, 13.5 Cat 1 AMA credits. Fee: \$495/physicians; \$295/physicians-in-training and allied health professionals. Info: Svetlana Lisanti, 201-385-8080. | Oct. 15-17 |
| New techniques and concepts in cardiology , sponsored by the American College of Cardiology at the Hyatt Regency on Capitol Hill, Washington DC. 16 Cat 1 AMA credits. Info: 800-257-4739 (outside the U.S. and Canada, 301-897-2695). | Oct. 20-22 |
| Annual business meeting , sponsored by the Baltimore City Medical Society at UMMS Davidge Hall. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. | Nov. 3 |
| GI and endocrine controversies for the family physician , sponsored by the Maryland Academy of Family Physicians, at the Bavarian Inn, Shepherdstown, WV. 6 Cat 1 AMA/PRA credits; 6 AAFP prescribed hours. Fee: \$55/members, \$75/ non-members, \$35/allied health professionals. No charge for residents, students, retired or life members. Info: Maria Delegado, 410-747-1980. | Nov. 5 |

Miscellaneous meetings (continued)

- Maryland Academy of Family Physicians 3rd annual mid-winter conference, at the Hyatt Regency, Baltimore. 10 Cat 1 AMA/PRA credits. 10 AAFP prescribed hours. Fee: \$115/members; \$175/nonmembers; \$75 allied health professionals; no charge/residents, students, MAFP retired and life members. Info: Maria Delgado, M.D., 410-747-1980.

Jan. 20-22
- Maryland Academy of Family Physicians 47th annual meeting and scientific session, at the Sheraton Fountainebleau Hotel and Conference Center, Ocean City, MD. 41.25 Cat 1 AMA/PRA credits, 41.25 AAFP prescribed hours. Fee: \$240/members; \$275/nonmembers; \$135/allied health professionals; no charge/residents, students, MAFP retired and life members. Info: Richard Colgan, M.D. 410-747-1980.

May 16-21

Continuously throughout the year

- Fluorescein angiography conference, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month, 8:00-9:00 am. Fee: none. Info: R. Classon, 410-337-4500.



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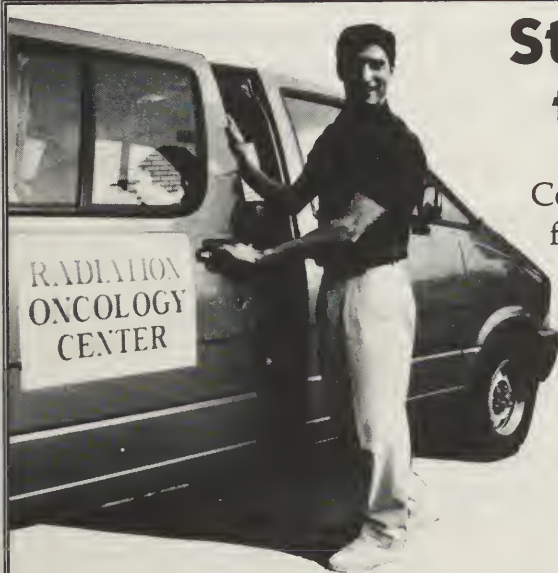
During June 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

- | | | |
|----------------------------|---------------------------|-------------------------------|
| George B. Albright, M.D. | Murray A. Kalish, M.D. | Alice P. Rieckelman, M.D. |
| Dahna L. Batts, M.D. | Sheppard Kaplow, M.D. | Steven D. Rock, M.D. |
| Robert S. Berger, M.D. | Richard J. Kolker, M.D. | Eric D. Rubin, M.D. |
| Belur S. Bhagavan, M.D. | Richard C. Lang, M.D. | Edward F. Sanford, M.D. |
| Anthony J. Calabrese, M.D. | Benigno R. Lazaro, M.D. | Lurette S. Semmes, M.D. |
| Joseph J. Colella, M.D. | Robert B. Lucas, M.D. | Lawrence P. Shombert, M.D. |
| Marcus G. Connelly, M.D. | Scott E. Maizel, M.D. | Mario Vahos, M.D. |
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| Linnie A. Delmonte, M.D. | Alka Mehta, M.D. | Boris G. Vialukin, M.D. |
| Robert F. Dyer, M.D. | Saverio Mirarchi, M.D. | James Vorosmarti, M.D. |
| Morris Z. Effron, M.D. | Ashwin I. Mehta, M.D. | Robert F. Ward, M.D. |
| Jose A. Gelpi, M.D. | Laura J. Mirkinson, M.D. | Sarah M. White, M.D. |
| Duane M. Gels, M.D. | Karla J. Montgomery, M.D. | Nancy C. O'Neil-Whitley, M.D. |
| Eric L. Greidinger, M.D. | Hong T. Nguyen, M.D. | John T. Whitmore, M.D. |
| John A. Gschwend, M.D. | Mark D. Noar, M.D. | |
| Yong H. Hwang, M.D. | Frederick W. Plugge, M.D. | |

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, Maryland. Info: 301-279-6115.

| | |
|----------------------------|---------|
| Allergic rhinitis | Aug. 4 |
| Tumor conference | Aug. 11 |
| Sleep disorders | Aug. 18 |
| Stroke & stroke prevention | Aug. 25 |



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EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

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July, 1994

Invasive Group A Streptococcal Disease

In June 1994, the Department of Health and Mental Hygiene (DHMH) was made aware of three fatal cases of invasive group A streptococcal disease (GAS) in Maryland children and one non-fatal case of necrotizing fasciitis in an adult. The children ranged in age from 2 to 5 years old. The four cases resided in Dorchester, Anne Arundel, and Worcester Counties. Two of the children had invasive group A streptococcal disease while recovering from chickenpox, while the third child had no known predisposing illness. None of the cases were linked to each other.

Invasive GAS infections are not reportable in Maryland nor in the remainder of the U.S. This lack of surveillance was highlighted when recent media attention focused on GAS causing necrotizing fasciitis--so-called "flesh-eating" disease--in England and in the United States. Public health authorities were left noting that invasive GAS disease is not new but were not able to accurately define expected levels of GAS against which to judge media reports. In Maryland we anticipate that invasive GAS disease occurs (see below), however, three deaths in children due to GAS in a two month period of time is above what is expected.

The state and local health departments worked together with the clinicians to investigate these cases. DHMH sent the GAS organisms from these cases to the federal Centers

for Disease Control and Prevention (CDC) in Atlanta for typing to determine whether the organisms were identical and whether they were similar to strains from severe infection in other parts of the country. The isolates from the children were all M1, T1; the isolate from the patient with necrotizing fasciitis was M3, T3. M3 has been associated with cases of necrotizing fasciitis in other parts of the country.

We present the following Questions and Answers for clinicians who may see or manage cases of invasive GAS infection.

Questions and Answers Regarding Group A Streptococcal Infection

What is group A streptococcus?

Group A streptococcus (GAS) is a bacterium that is commonly found on the skin, and in the throat.

What kinds of disease does GAS cause?

GAS cause a range of diseases from the common "strep throat" and GAS skin infections (pyoderma and impetigo) to the less common but potentially life threatening infections such as septicemia, meningitis, cellulitis, necrotizing

fasciitis, endocarditis, osteomyelitis, and streptococcal toxic shock syndrome (STSS).

GAS can also be carried in the throat or on the skin of a person and cause no symptoms for that individual.

What is "strep throat" or strep pharyngitis?

Strep pharyngitis and tonsillitis are the most common clinical illnesses produced by GAS. "Strep throat" is most common in children 5-10 years old, but can occur at any age. People with strep throat have a fever, sore throat, malaise, headache, and swollen lymph nodes. When strep throat is accompanied by a rash, it is often called scarletina or scarlet fever.

What is strep toxic shock syndrome?

Beginning in 1987, patients were described as having disease similar to staphylococcal toxic shock syndrome, but the causative organism was GAS. This syndrome has been called streptococcal toxic shock syndrome (or STSS). The characteristic features of STSS are the occurrence of shock (low blood pressure) and multiorgan failure early in the course of infection. The organ systems affected are the kidneys, liver, and lungs (adult respiratory distress syndrome). The blood clotting system is affected and platelets may be low, and disseminated intravascular coagulation may occur. Patients may have a generalized red flat rash, and there may be soft tissue necrosis such as necrotizing fasciitis, myositis, or gangrene.

STSS may be a challenge to diagnose because of the dramatic clinical presentation of a patient appearing to have signs of toxicity with shock and multiorgan failure following a nonspecific prodromal illness.

How common are severe group A strep infections?

Studies conducted in the late 1980s indicated that severe GAS infections may be becoming more common. Based on surveillance data

from 1990, the CDC estimates that 10,000 to 15,000 severe infections occur in the U.S. each year, resulting in 2,000 to 3,000 deaths annually. Necrotizing fasciitis is felt to account for 5 to 10% of all severe group A strep infections. Intensive surveillance in the U.S. for severe group A streptococcal infections has not been conducted since 1991.

Dr. Timothy Cote of the DHMH cooperated with Maryland hospital infection control practitioners and microbiology laboratories in active surveillance for GAS bloodstream infection in 1989-1990. During the one year period in Maryland, there were 155 cases reported, 20% of which were fatal. Four cases of necrotizing fasciitis with bacteremia were reported. Ten of the 155 cases occurred among children; none of whom died. The rates of illness were highest in the elderly.

What determines whether a person gets mild or severe infection with GAS?

The difference lies in both the individual who acquires GAS and in the strain of GAS that the person catches.

What are some risk factors for severe invasive GAS?

Some risk factors make it more likely that an individual will be a "susceptible host." These include having a break in the skin such as a wound or just having had surgery or recent chickenpox infection, underlying disease such as cancer or other immunosuppression, diabetes, chronic disease of the heart or lungs, alcoholism, and injectable drug use. Older adults have a higher risk of invasive GAS infection.

What are the differences between GAS strains?

The infectious agent, Streptococcus pyogenes, group A streptococci, occurs in approximately 80 serologically distinct types which may vary greatly in geographic and time distributions. GAS producing skin infections are usually of

different serologic types from those associated with throat infections.

In the U.S., GAS infections due to a limited number of specific types of M protein (M-types), especially types 12, 1, 3, 4, and 25, have frequently been associated with the development of acute glomerulonephritis.

Data suggest that certain GAS strains are more likely to be associated with severe disease. Isolates of GAS can be serotyped and tested for the production of pyrogenic (fever-causing) exotoxins and protease activity. M-types 1 and 3, and isolates that have protease activity and produce pyrogenic exotoxin are most commonly associated with invasive GAS disease in a susceptible host. Production of proteases is one factor that may be linked to necrotizing fasciitis. Proteases are enzymes that break down proteins.

How does necrotizing fasciitis kill?

Persons with necrotizing fasciitis are likely to develop spread and growth of GAS in many areas, including the bloodstream. When this growth continues unchecked it can lead to overwhelming bacterial infection and death.

Are there any recommendations for prevention of necrotizing fasciitis?

Necrotizing fasciitis often occurs in persons with wounds due to injury or surgery which become infected. Persons with such wounds should take appropriate measures to keep the wounds clean and should seek medical attention if signs of infection occur. These infections can be treated with readily available antibiotics.

What is the association between GAS and chickenpox?

Recent chickenpox infection is one well-recognized risk factor for invasive GAS infection, although GAS infections following chickenpox are rare. The fatality rate in severe GAS

infections following chickenpox, however, may be as high as 15-20%. In California in 1994, there have been 20-30 cases of invasive GAS infections following chickenpox, and 6 deaths.

What are the recommendations for persons with chickenpox?

Persons concerned about a fever or other signs of infection should check with their doctor. If a child has chickenpox, parents should be aware that it is appropriate to bathe the child and keep the skin surface clean since GAS infection often begins with an infection of the skin. Keeping fingernails short and clean in order to avoid scratching and infecting the chickenpox lesions may also be helpful. If there are any signs of skin infection such as fever, redness, warmth, swelling, the parents should check with their doctor.

Children with chickenpox often have a fever, but that fever usually goes away within the first 2-3 days. If the fever goes away and then comes back or if the fever lasts more than 3-4 days, parents should be told to contact their child's doctor.

How are strep infections treated?

Rapid treatment is necessary to reduce the risk of death and penicillin remains the treatment of choice for GAS. Although penicillin resistance has never been identified in GAS, some strains are resistant to erythromycin (which is recommended as therapy in penicillin-allergic patients). In addition to antibiotics, surgical intervention is usually needed in cases of necrotizing fasciitis.

There are animal studies and anecdotal reports suggesting that treatment with clindamycin may be more effective than penicillin in toxin mediated infection. However, because of potential resistance to clindamycin, a beta-lactam antibiotic should be used in association with clindamycin. The Communicable Disease Surveillance Center, Public Health Laboratory Action Group in England (May 27, 1994) endorsed immediate treatment of all clinically

suspected cases of invasive streptococcal disease with benzylpenicillin (2.4 g at 4 hourly intervals)*. Clindamycin (0.6 to 1.2 g at 6 hourly intervals) should be considered as additional treatment in severe cases (with reductions in dosage for children and reference to appropriate contraindications).

Are contacts of cases of invasive GAS at increased risk?

There have been clusters of GAS invasive disease reported in the U.S. and reports of cases of invasive GAS in household contacts or others in intimate contact with infected secretions cases. Host susceptibility is important. Investigation of family clusters shows that the same type of bacteria can cause severe infection in one family member and mild or asymptomatic infection in others.

What is the appropriate management of contacts of invasive GAS infection?

Contacts of documented cases of invasive GAS infection who have recent or current clinical evidence of a streptococcal infection should see their doctor. Doctors should consider

getting strep cultures of appropriate sites and treat the symptomatic contacts. If there is a good history or suspicion of GAS infection in the contact, treatment may be started empirically while waiting for the culture results, and continued even if cultures are negative (e.g., cellulitis that may be culture negative). DHMH would also recommend culturing the throat and any skin lesions of asymptomatic household contacts. These individuals should be treated if the cultures are positive. For other contacts who had intimate contact with infected secretions of invasive GAS infection (e.g., person stuck with a needle used to aspirate infected fluids), prophylactic treatment may be warranted on a case by case basis.

Treatment or prophylaxis consists of a full course of antibiotics (such as penicillin three to four times/day) with rifampin given concurrently for the last four days of therapy to eradicate carriage.

References available on request: (410) 225-6031.

*Not licensed in the U.S.; use high dose I.V. penicillin G.

Vaccines for Children Program to Begin on 10/1/94

The Federal Vaccines for Children (VFC) Program is scheduled to begin on October 1, 1994. VFC will provide vaccine for eligible children throughout the U.S. A child is eligible for VFC vaccine who is 18 years or under and:

- has Medical Assistance,
- is uninsured,
- is Native American or Alaskan Native, or
- is underinsured.

In Maryland, we are adding funds from other Federal sources to the VFC funds in order to provide vaccine for underinsured clients seen in private practices.

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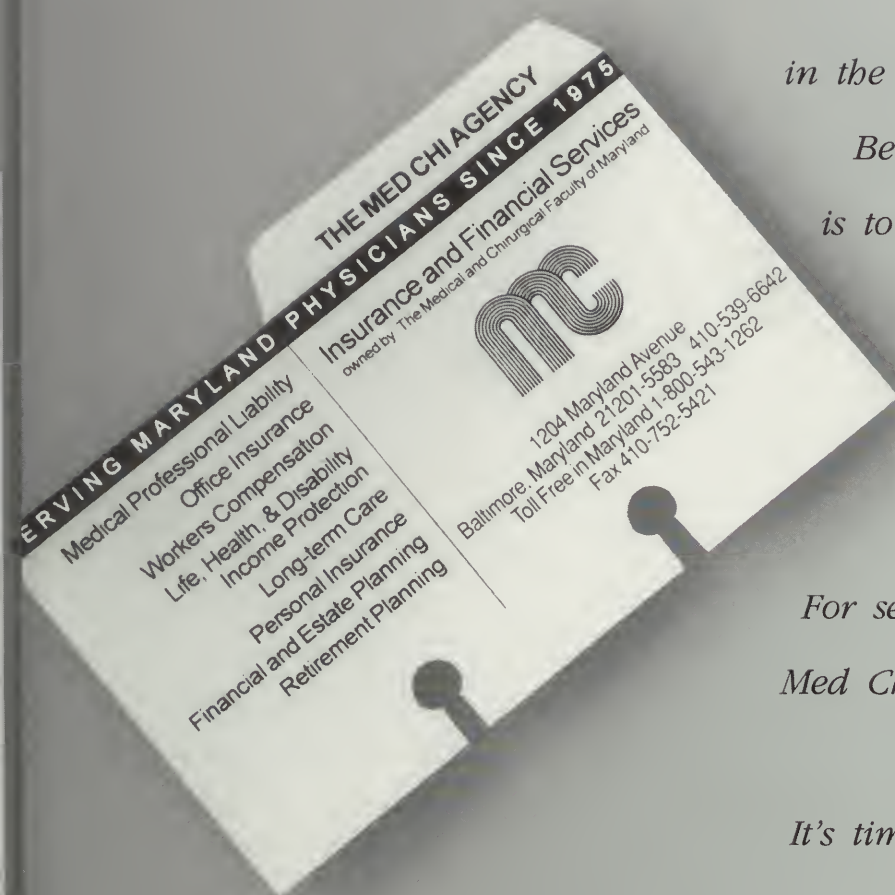
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GRANT REPORTS

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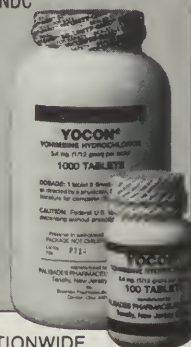
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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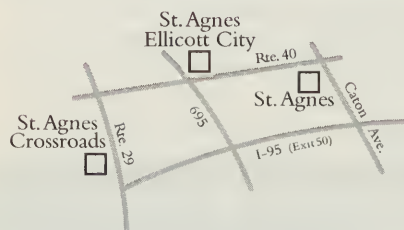


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Chief Executive Officer's Newsletter

August 1994

1994 Semiannual Meeting Preliminary Program

A preliminary program, including registration form, for the 1994 Med Chi Semiannual Meeting, being held September 9 - 11, 1994, at the Sheraton Ocean City Resort and Conference Center, has been mailed to all Med Chi members. If you did not receive a program and you need a registration form, please contact the Med Chi communications department at 410-539-0872 or 1-800-492-1056.

Med Chi Receives Robert Wood Johnson Grant

Med Chi is one of 19 grant recipients selected by the Robert Wood Johnson Foundation to receive funding as part of the Foundation's SmokeLess States Program. Med Chi was awarded a two-year capacity building grant that will be used to expand and strengthen "Smoke Free Maryland — A Coalition for Tobacco Control," establish a statewide tobacco control clearinghouse, and promote public awareness of and mobilize public support for progressive tobacco control policies. The funds awarded to the recipients in 19 states from the Robert Wood Johnson Foundation represent the largest philanthropic initiative aimed at tobacco prevention and control.

American College of Physicians Receives CDC Grant for Lyme Disease Research

The Centers for Disease Control and Prevention (CDC) recently awarded the American College of Physicians (ACP) \$220,000 in the first year of a three-year cooperative agreement for a new ACP educational program on Lyme disease. The project is designed to improve diagnosis of the disease, reduce inappropriate testing for and treatment of suspected Lyme disease, and increase physician reporting of cases for CDC surveillance. The project will consist of developing a CME program including a one-hour videotape presentation on diagnosis and management of Lyme disease, as well as additional videotaped and print materials with clinical case vignettes and assessment materials. Maryland will be one of the first program sites, and materials are expected to be ready in the spring of 1995.

Baltimore City Medical Society Celebrates Women in Medicine Month

The Baltimore City Medical Society will celebrate September as Women in Medicine Month with a window exhibit at the central branch of the Pratt library. The exhibit theme is "Women in Medicine - Women on the Move," and will highlight the accomplishments of several Baltimore women physicians from the late 19th century to the present. For additional information about the exhibit contact Lee C. Roebuck at 410-625-0022.

*Report of Resolutions
and Reference
Committee
Recommendations -
July 21, 1994 House of
Delegates Meeting*

Resolutions and recommendations are listed here in final form with only the wording as approved by the House of Delegates. For a report of the resolutions as originally submitted to the reference committees, including amendments made during discussion, please contact Arlene Whalen at 410-539-0872 or 1-800-492-1056.

After hearing the recommendations of Reference Committee A, the following resolutions were approved as follows by the Med Chi House of Delegates on July 21, 1994:

INCLUSION OF SELF-INSURED UNDER HCACC LAW (RESOLUTION 2-94)

RESOLVED, That Med Chi urge self-insured employers in Maryland to participate equally in the health insurance reform plan of 1993; and be it further

RESOLVED, That Med Chi urge the state of Maryland to seek an ERISA exemption so that all Maryland employers can be required to participate equally in health system reform in Maryland.

***DISTRIBUTION OF BACKGROUND INFORMATION ON NOMINEES
(RESOLUTION 3-94)***

RESOLVED, That qualifications on all candidates for office presented by the Nominating Committee be distributed to the members of the House of Delegates with the call to the session at which the election is to be held; and be it further

RESOLVED, That qualifications on anyone nominated from the floor will be distributed at the time the nomination is made; and be it further

RESOLVED, that the Board of Trustees develop a mechanism for evaluating and reporting the qualifications of the BPQA nominations.

PARKING FOR THE HOUSE OF DELEGATES (RESOLUTION 6-94)

RESOLVED, That the Board of Trustees obtain a parking area adequate to accommodate all attendees at House of Delegates Meetings.

PATIENT CHOICE PUBLIC RELATIONS CAMPAIGN (RESOLUTION 7-94)

RESOLVED, That Med Chi approve sufficient funds as determined by the Board of Trustees and if necessary to assess members in order to retain a public relations firm to develop and implement a public information campaign to inform the public of the need of the enactment of patient access legislation.

***CONGRESSIONAL HEALTH CARE LEGISLATION (RESOLUTION 9-94) and
FEDERALLY CONTROLLED HEALTH PLANS (RESOLUTION 10-94)***

RESOLVED, That the Medical and Chirurgical Faculty of Maryland reaffirm its support of AMA policy to achieve universal access and coverage through an approach that may utilize employer and/or individual responsibilities for payment while permitting the individual to choose and own his or her health insurance plan, and continue to encourage health IRAs and a phase-in mechanism, exploring all concepts that accomplish coverage for and access to health services for all Americans recognizing the needs of individual states; and be it further

RESOLVED, That the Medical and Chirurgical Faculty of Maryland may support a health system reform bill that does not include every component of the current AMA Health System Reform policy; and be it further

RESOLVED, That the Medical and Chirurgical Faculty of Maryland support the Patient Protection Act.

COMMUNICATION PROBLEMS (RESOLUTION 11-94)

RESOLVED, That the Medical and Chirurgical Faculty of Maryland meet with the leadership of Med Chi's neighboring states and the District of Columbia; and be it further

RESOLVED, that this resolution be referred to the Council on Planning and Development for implementation.

FEDERALLY CONTROLLED HEALTH PLANS (RESOLUTION 13-94)

RESOLVED, That the Medical and Chirurgical Faculty of Maryland express its opposition to existing and proposed federal health care legislation which includes punitive aspects such as fines and imprisonment on physicians.

SINGLE PAYOR SYSTEM (RESOLUTION 14-94)

RESOLVED, That the Medical and Chirurgical Faculty of Maryland request the AMA to advise all legislators promoting a single payor system of those features which would be acceptable to physicians and the American public.

CONSENT CALENDAR: CHOICE OF DAY FOR THE INTERIM HOUSE OF DELEGATES MEETINGS (RESOLUTION 5-94)

RESOLVED, That the interim meetings of the House of Delegates be held on Saturdays.

After hearing the report of the Reference Committee on Bylaws, the following Bylaws Committee recommendations were approved as follows by the House of Delegates on July 21, 1994:

5.503 Speaker and Vice Speaker. There shall be a speaker and a vice speaker of the House of Delegates who shall be nominated under the provisions of Article 8.00 of these bylaws and elected from the membership of the House at each annual general meeting. Any member may serve as speaker or vice speaker for a maximum of six consecutive terms in either position. The speaker, or in his or her absence the vice speaker, shall preside over all meetings of the House.

7.20 Composition. The Board of Trustees shall be composed of:

- b. Speaker of the House of Delegates with full voting priveleges through operational year 1994;
- c. Vice speaker of the House of Delegates with full voting priveleges through operational year 1994;

8.103 Duties. The Nominating Committee shall interview all candidates and shall recommend one to three nominees for each position to be filled on the basis of the criteria set forth in the rules of Med Chi, except as otherwise provided in these bylaws. All nominees for elective position shall be sent to the members of the House of Delegates with the call to session.

9.201 Council on Bylaws. The function of the Council on Bylaws shall be to draft amendments to the bylaws and rules of Med Chi as it deems are needed or as directed by the House of Delegates or Board of Trustees. It shall review, approve, disapprove, or alter amendments submitted to it by component societies or councils. It shall report all amendments to the bylaws of Med Chi to the House of Delegates with the call to session. The Council shall also

serve as an advisory committee on all matters pertaining to the bylaws and rules of Med Chi.

A bylaws amendment had been submitted for Section 7.20g. The Bylaws Committee had recommended that Section 7.20g not be amended.

5.20 Duties. The House of Delegates shall have the following duties:

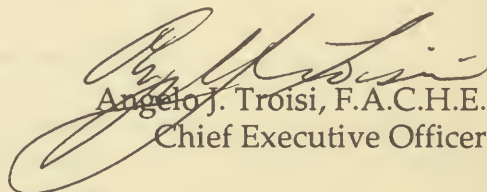
e. To establish rules to govern the conduct of the business of the House.

16.10 Adoption. Rules necessary for the conduct of the work of Med Chi shall be adopted and amended as necessary by the Board of Trustees. Such rules and amendments shall be presented to the House of Delegates at its next meeting and shall become final if no action is taken by the House.

Delete Section 16.20 Amendments, 16.201 Board of Trustees; 16.202 House of Delegates and 16.203 Approval.

10.20 Reporting. All funds shall report annually or as additionally required by the Board of Trustees through the Finance Committee to the Board of Trustees which shall report to the House of Delegates.

11.30 Resolutions. Resolutions to be introduced into the AMA House of Delegates as a Maryland delegation resolution shall be submitted to the Med Chi AMA delegation and the Board of Trustees for review and approval prior to submission of a proposed resolution except that the House of Delegates may direct the AMA delegation to submit any resolution to the AMA House of Delegates.



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Chief Executive Officer

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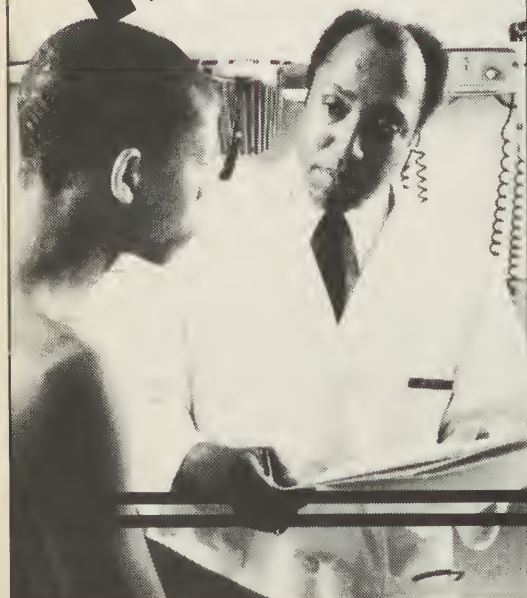
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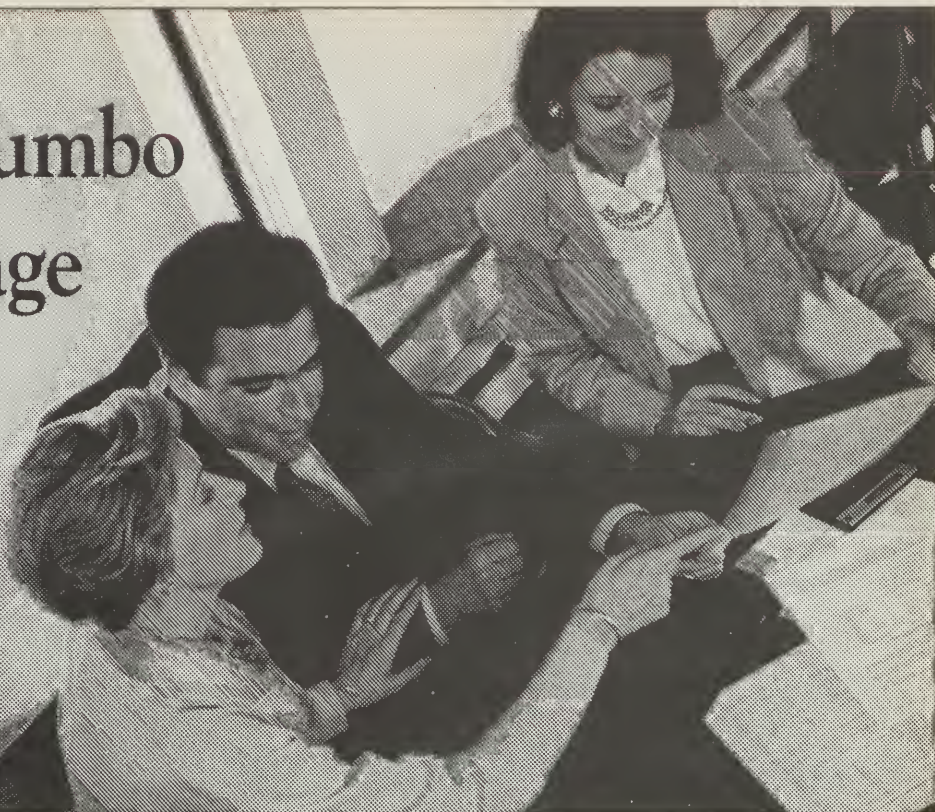
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Minutes of the House of Delegates—342nd Session—May 13, 1994

❖ *Members, guests, and staff present*

The attendance list was submitted to all House of Delegates members. The roster is on file in the Med Chi executive department.

❖ *Call to order*

The 342nd session of the House of Delegates was called to order by the president and chairperson, Joseph Snyder, M.D., at 2:50 p.m., Friday, May 13, 1994, at the Ramada Inn and Convention Center in Hagerstown, Maryland.

❖ *Invocation and National Anthem*

Max E. Byrkit, M.D., delivered the invocation and the 1994 All State Junior Chorus from Clear Spring Middle School sang the National Anthem.

❖ *Visiting dignitaries*

The chairperson acknowledged the following visiting dignitaries:

- ✦ Robert E. McAfee, M.D., AMA president-elect
- ✦ Michael J. Bradley, D.O., Medical Society of Delaware president-elect
- ✦ John H. Hobart, M.D., Pennsylvania Medical Society president-elect
- ✦ Paul E. Galanti, Medical Society of Virginia deputy executive vice president
- ✦ Angus McBryde Jr., M.D., Southern Medical Association president
- ✦ Darlene Young, AMA Alliance secretary
- ✦ JoAnn Daus, Southern Medical Auxiliary president-elect
- ✦ Donald "Ted" Lewers, M.D., AMA board of trustees member from Maryland

The chairperson noted that if anyone wished to speak, they could do so at the Saturday House of Delegates meeting.

❖ *Announcements*

The chairperson noted that Angus Everton, Esq., Med Chi's general counsel, would serve as parliamentarian and asked the Delegation to note the announcements on their agenda as well as the rules of the House. The chairperson stated that in the interest of time there would be modifications in the order in which topics were to be presented and requested that when the delegates had the privilege of the floor, they were to announce their name and component medical society.

The Honorable Bill Brightner, Council member of Hagerstown, welcomed the members of the House of Delegates to Hagerstown. A proclamation presented to Med Chi from the City of Hagerstown and accepted by the chairperson proclaimed "May 13, 1994, Medical and Chirurgical Faculty Appreciation Day in Hagerstown, in appreciation of the outstanding services rendered by the members of this profession." Med Chi presented a certificate of appreciation to the mayor of Hagerstown, the Honorable Steve Sager.

❖ *Keynote address*

The chairperson introduced Robert McAfee, M.D., president-elect of the AMA, vice chairman of the AMA board of trustees, and a member of the executive committee of the board. The chairperson noted that Dr. McAfee would be leading the AMA through health system reform. Dr. McAfee spoke about health system reform and stressed the following points:

1. U.S. health care is the envy of the world.
2. The United States has the ability to assimilate technology rapidly and to work with patients to improve their care.
3. The health care system has become expensive and not accessible to some individuals, so as to prompt a majority of the people in the United States to feel it should be improved.
4. The AMA has met with the President, the First Lady, and White House administrators to discuss health system reform and present its Health Access America Plan.
5. The AMA continues to be active in the dialogue on health system reform.
6. There are positive aspects to the federal plans, including universal health care access and a basic benefits package.
7. The AMA agrees with the federal plans that would eliminate preexisting conditions and community rating clauses as well as administrative hassles.

Dr. McAfee also discussed the Patient Protection Act, which is to be introduced into Congress. If this bill passes, it would require insurers to provide patients with a list of covered and excluded services; clear instructions on preauthorization review and other UR requirements; an explanation of how coverage limits and UR affects them; and survey data on the plans, including the patient satisfaction rate, three coverage options, and access to a point-of-

service plan. The Patient Protection Act would also provide that insurers are required to give physicians a voice in medical policy-making and quality standards, quality-based credentialing criteria, due process rights and protection from termination without cause, and access to UR criteria.

Dr. McAfee noted that the quality issue was an after-thought in the Clinton plan. He stated that everyone needs to insist that the quality of care that the United States now has is kept intact and that physicians are assured that the quality as measured by them is upheld for the future.

Dr. McAfee noted that in the 1960s, the federal government had asked for an increase in medical specialists to treat individuals over age 65; it was noted, however, that the government made a mistake and now wants medical schools to graduate more primary care physicians. Dr. McAfee concluded that physicians have a right to choose how they are going to spend their lives, in what capacity, in what specialty, and where they are going to live and practice.

The chairperson presented Dr. McAfee with a certificate of appreciation.

❖ *Remarks of the president*

Dr. Snyder thanked the House of Delegates for giving him the honor of serving them during the past year and said it "had been a great pleasure." He had traveled to many states to represent Med Chi on deliberations on health system reform. Dr. Snyder noted that what has been done at Med Chi during the past year could not have been done without the stellar work of the Executive Committee. He asked the committee to stand and be recognized for its hard work during the past year. Dr. Snyder said he appreciated the help he received during the last year.

❖ *Approval of minutes*

The minutes of the 341st meeting of the House of Delegates, which was held September 11, 1993, at the semiannual meeting, were approved by the Executive Committee on November 18, 1993. The minutes were presented to the House, which approved them.

❖ *Necrology*

The secretary noted that the names of the deceased members had been mailed with the call of the House. However, names had been added since the mailing and the secretary read their names. The House approved dispensing with reading the list of names that were mailed.

The complete necrology list was as follows:

Allegany County

Harold C. Diehl, M.D., July 6, 1993

Thaddeus H. Elder, Jr., M.D., August 10, 1993

Anne Arundel County

John T. Smith, M.D., May 1, 1993

Baltimore City

Donald M. Barrick, M.D., January 7, 1994

Harry M. Beck, M.D., December 3, 1993

Annie M. Bestebreurtje, M.D., November 11, 1993

Nathan Block, M.D., October 3, 1993

John E. Bordley, M.D., July 12, 1993

Maxie Collier, M.D.

Edward H. Davis, M.D., June 1, 1993

Jeremy D. Hallisey, M.D.

Nathan B. Hyman, M.D., December 12, 1993

Leon A. Kochman, M.D., October 29, 1993

John Lesinsky, M.D.

Virginia Ling, M.D., July 23, 1993

Ephraim T. Lisansky, M.D., August 16, 1993

Harry A. Miller, M.D., July 14, 1993

William H. Mosberg, M.D., December 27, 1993

Melvin F. Polek, M.D., May 20, 1993

Irvin Sauber, M.D., April 1, 1993

Edward S. Stafford, M.D., November 18, 1993

Sigmund J. Toth, M.D., March 14, 1994

Thomas C. Webster, M.D., April 7, 1993

Baltimore County

Ali H. Afrookteh, M.D., October 9, 1993

Ki H. Bang, M.D., July 1, 1993

Lester H. Caplan, M.D.

George M. Baumgardner, M.D., March 5, 1994

Alfred S. Garrison, M.D.

Cary M. Glasser, M.D., May 23, 1993

Paul F. Guerin, M.D.

Edward J. Kitlowski, M.D., September 27, 1993

Bernard S. Kleiman, M.D., October 26, 1993

Paul G. Koukoulas, M.D.

William A. Rinn, M.D., June 6, 1993

Martin E. Strobel, M.D., July 14, 1993

Millard T. Traband, Jr., M.D., October 10, 1993

Carroll County

Thomas F. Vestal, M.D.

Frederick County

Charles H. Conley, M.D., November 6, 1993

Henry L. McCorkle, M.D., November 14, 1993

Howard County

George E. Groleau, M.D., May 31, 1993

Kent County

Alexander Dick, M.D., January 17, 1994

Montgomery County

Luis F. Bentolila, M.D., March 24, 1994

Corinne Cooper, M.D., February 26, 1994

John A. Dowling, M.D., December 5, 1993

Robert W. Eckel, M.D., August 30, 1993
 Donald Q. Ekman, M.D., April 23, 1993
 Peter N. Lombard, M.D., November 23, 1993
 Michael S. Madeloff, M.D., December 31, 1993
 Henry C. Mellette, M.D., March 15, 1994
 Reginald H. Mitchell, M.D.
 Norman Oliver, M.D., July 21, 1993
 Ralph Stiller, M.D., October 2, 1993
 Merton L. White, M.D., August 12, 1993
 Thomas M. Wilson, M.D., July 31, 1993

Prince George's County

Wolcott L. Etienne, M.D., December 21, 1993
 David S. Gordon, M.D., January 30, 1994
 Lloyd Hughes, M.D., February 1, 1994
 John A. Kehoe, M.D., December 26, 1993
 Lawrence W. Malin, M.D.

Talbot County

Arthur B. Cecil, M.D., May 10, 1993

Washington County

Henry F. Graff, M.D., April 14, 1993

Wicomico County

Frank E. Poole, M.D., November 12, 1993

Affiliates

Arturo C. Uy, M.D., April 23, 1993

❖ *Memorial resolution*

The following memorial resolution was adopted by the House:

***Frank E. Poole, M.D.
 1918-1993***

Whereas Frank E. Poole, M.D., born in West Virginia in 1918, received his medical degree from the Duke University School of Medicine, and served residencies in general and orthopedic surgery in West Virginia and the Veteran's Administration Hospital at Fort Howard, Maryland; and

Whereas he practiced orthopedics in Salisbury for more than 25 years, until his retirement in 1979; and

Whereas Dr. Poole had served as an active member of the Wicomico County Medical Society and subsequently was elevated to emeritus membership; and

Whereas he had long been a member of the Medical and Chirurgical Faculty of Maryland; and

Whereas he will be long remembered among his colleagues as a gentleman, a caring physician and surgeon, and a friend who will be missed; and

Whereas the Wicomico County Medical Society and the Medical and Chirurgical Faculty of Maryland express their sympathy to his family: Now, therefore be it

Resolved, That this resolution be spread upon the minutes of the House of Delegates at its annual meeting, with a copy sent to his wife, Mrs. Margaret Poole.

❖ *Award presentations*

a. 50-Year certificates. Med Chi members who had attained 50 years of service were honored; the following honorees were present:

Baltimore City

Katherine H. Borkovich, M.D.
 Ross P. Pierpont, M.D.

Baltimore County

John C. Norton, M.D.

Washington County

Robert V. Campbell, M.D.

It was noted that Dr. Borkovich was the first woman president of the Baltimore City Medical Society. Others who were unable to attend this meeting were as follows:

Baltimore City

Jess N. Borden, M.D.
 E. Ellsworth Cook, M.D.
 Frederic A. Glass, M.D.
 Julius A. Gluck, M.D.
 John S. Haines, M.D.
 Charles E. Iliff, M.D.
 Franklin E. Leslie, M.D.
 Deonis M. Lupo, M.D.
 Arthur T. Ward, M.D.
 John D. Young, Jr., M.D.

Baltimore County

Gertrude Fleischmann, M.D.
 Oscar Hartman, M.D.

Howard County

Irving J. Taylor, M.D.

Affiliate

Robert C. Austrian, M.D.

b. American Medical Association Education and Research Foundation (AMA-ERF) awards. It was noted that contributions to the AMA-ERF fund in 1993 totaled more than \$30,000. Almost \$22,000 was contributed by Med Chi members. Elizabeth Linhardt, chairperson of the Maryland AMA-ERF fund, and Georgia Lizas, president of the Med Chi Alliance, helped to present the checks to the three medical schools.

Roland Smoot, M.D., associate dean of student affairs, accepted the \$10,000 check in unrestricted funds and the \$7,500 check in restricted funds for the medical student assistance program of The Johns Hopkins University School of Medicine.

Ms. Ruth Bulger, vice president of the Henry M. Jackson Foundation for the Uniformed Services University of the Health Sciences, accepted two checks to be used by that school.

James P.G. Flynn, M.D., director of corporate rehabilitation services of the University of Maryland School of Medicine, accepted the \$16,000 check in unrestricted funds for the medical school's excellence program and a check for more than \$10,000 in restricted funds for the medical schools's student assistance program.

c. Wyeth-Ayerst Laboratories Physician Award for Community Service. The Wyeth-Ayerst Laboratories Physician Award for Community Service is presented to a physician who has provided outstanding service to his/her community outside the field of medicine. This year's recipient was Frank Pedreira, M.D., for his efforts in promoting better health care in the community for indigent, homeless women; floating hospitals in third world countries; and his Christian ministry work. Pati Prochaska from Wyeth-Ayerst Laboratories presented the award to Dr. Pedreira. Dr. Pedreira noted that this was a great honor and privilege for him to receive the award. He noted how fortunate U.S. physicians are to be able to practice in this country and that the United States excels in the world of medicine. He also related his experiences with practicing medicine in third world countries and the importance of his religion and family in his work.

d. Certificates of recognition and appreciation. The chairperson presented certificates of recognition to the following four physicians for their outstanding service and dedication as chairpersons of Med Chi committees:

- ♦ *Ronald J. Cohen, M.D.*, Peer Review Management Committee
- ♦ *J. Ramsay Farah, M.D.*, HMO Quality Care and Practice Parameters Technical Advisory Committee
- ♦ *Hilary T. O'Herlihy, M.D.*, Legislative Committee
- ♦ *Martin P. Wasserman, M.D.*, Committee on Public Health

The chairperson presented certificates of appreciation for outstanding support of Med Chi ideals to Senators Laurence Levitan and Patricia R. Sher.

e. Henry and Page Laughlin Award. The chairperson presented the Henry and Page Laughlin Award and introduced Henry Laughlin, M.D., to the Honorable Louis Goldstein, comptroller of the State of Maryland. Dr. Laughlin noted that Mr. Goldstein was loved not only by physicians, but by all the citizens of Maryland. Mr. Goldstein thanked Med Chi.

f. Governor's Citation. On behalf of Maryland, the Honorable Senator Laurence Levitan presented Med Chi with the Governor's Citation for the excellent accomplishments of Med Chi's Focused Professional Education Program. Dr. Snyder accepted the citation on behalf of Med Chi.

g. Malouf/Wagner awards. Before presenting the Malouf and Wagner Awards, the chairperson noted how they were established. In 1991, Henry Wagner, M.D., received the AMA's Scientific Award and George Malouf, Sr., M.D., received the AMA's Benjamin Rush Award for outstanding community service. Both physicians donated the monetary portion of their award to Med Chi to be used as incentives for the youth of Maryland. Dr. Malouf presented the Malouf Award for Community Service to Dannah Card and Dr. Wagner presented the Wagner Science Award to Kevin Seivers.

h. Photo contest. The Public Relations Committee sponsored Med Chi's 14th annual photo contest. The first place winner was Alan V. Abrams, M.D., and the second place winner was Michael Liteanu, M.D.

❖ *Legislative update*

The chairperson noted that Med Chi's lobbyist, Joseph Schwartz, Esq., had updated the Council and referred the House's attention to the packet that was mailed to all House members. Dr. Snyder thanked the following individuals for their hard work during the legislative session: Mr. Schwartz and his assistant, Geraldine Valentino, Esq.; the Legislative Committee chairperson, Hilary T. O'Herlihy, M.D.; the committee's two vice-chairpersons, Arnold Levy, M.D., and William Bruther, M.D.; and Jennifer Odenwald.

Mr. Schwartz said that during the six months he has been Med Chi's lobbyist, "We have been able to build consensus." He said consensus building is a positive legislative tool that was going to take place in the medical society and in the component societies as well as with the allied health professional groups.

❖ *Nominations*

Before calling for the Nominating Committee's report, the chairperson announced the tellers for the election to be held May 14, 1994: Hilda Houlihan, M.D., chief teller; John Newby, M.D.; Allan Leffler, M.D.; Murray Kalish, M.D.; and Mark Seigel, M.D.

The chairperson announced that there would be one speaker per candidate and that the speaker would be limited to three minutes. The secretary would be the timekeeper. Noting no objections, the procedures were put into place. The chairperson also announced that nominating speeches

would be made today (May 13, 1994) and that speeches would be by position in alphabetical order in each position. He said a majority of the votes cast would be necessary for election for any position. He said if any candidate obtained a majority, he or she would be elected and a ballot would be needed among the other nominees. If no candidate received a majority of the votes cast, the election would be held over as to that office and the same nominees would stand. He said if no candidate received a majority of votes on the second ballot, the candidate receiving the least number of votes would be removed from the ballot and a third ballot would be held. A ballot containing fewer votes than positions to be filled would be valid, but a ballot containing more than the number of positions to be filled would be counted as invalid.

Jose M. Yosuco, M.D., chairperson of the Nominating Committee, then presented the committee's report as follows:

- ♦ *President-elect:*
J. Richard Lilly, M.D.
- ♦ *First vice-president:*
Alex Azar, M.D.
- ♦ *Second vice-president:*
J. Ramsay Farah, M.D.
- ♦ *Third vice-president:*
Thomas Allen, M.D.
- ♦ *Treasurer:*
Carol W. Garvey, M.D.
- ♦ *Secretary:*
Paul A. Stagg, M.D.
- ♦ *Finney Fund Committee:*
Hiroshi Nakazawa, M.D.
- ♦ *Delegate to the AMA (January 1, 1994 to December 31, 1995):*
Alex Azar, M.D.
- ♦ *Delegates to the AMA (January 1, 1995 to December 31, 1996):*
Joseph Snyder, M.D.
J. David Nagel, M.D.
- ♦ *Alternate delegates to the AMA (January 1, 1995 to December 31, 1996):*
Jose M. Yosuco, M.D.
Carol W. Garvey, M.D.

Dr. Yosuco said the Nominating Committee reviewed the actions of the Council at its July 15, 1993, meeting and moved to reaffirm that action to name Carol W. Garvey, M.D., to fill the vacancy of alternate delegate created by the resignation from that position by Alex Azar, M.D., who was appointed to fill the term of Donald "Ted" Lewers, M.D., who resigned due to his election to the AMA board of trustees in 1993. Further, the Nominat-

ing Committee reviewed the actions of the Council at its November 18, 1993, meeting and moved to reaffirm the action taken to name Michael Armstrong, M.D., resident, to fill the vacancy of alternate delegate created by the resignation of the resident physician, Eric Shampaine, M.D.

The chairperson noted that the motion was to reaffirm Council's action taken in filling the delegate and alternate delegate positions. The House of Delegates reaffirmed Council's action in filling the delegate and alternate delegate positions.

Dr. Yosuco then presented the names of the individuals on the ballot for the Board of Physician Quality Assurance vacancies as follows:

- Richard L. Cohen, M.D.
- William Crawley, M.D.
- Tyler C. Cymet, D.O.
- Riad Dakheel, M.D.
- Stanley Z. Felsenberg, M.D.
- Robert S. Goodwin, D.O.
- Geetha Jayaram, M.D.
- John T. Lynn, M.D. (incumbent)
- Barbara R. Shoback, M.D.
- John F. Strahan, M.D. (incumbent)
- Ronald J. Taylor, M.D.
- Daniel J. Winn, M.D.

Dr. Yosuco said House of Delegates members would vote for the BPQA positions by ballot during the second session of the House of Delegates and that all other Maryland physicians would vote in the Crystal Ballroom after 2:00 p.m. on Saturday (May 14, 1994).

The chairperson then repeated the names of the nominees for each office and asked if there were any other nominees. There were no other nominees for the offices of president elect; first, second, and third vice-presidents; secretary; treasurer; Finney Fund; and AMA delegate January 1994 through December 1995. Therefore, the nominations were closed on these positions. The chairperson said that the positions of delegate and alternate to the AMA were incompatible; therefore, a nominee for the position of AMA delegate could not simultaneously run for the position of alternate delegate.

Dr. Snyder said for the position of AMA delegate January 1995 through December 1996, nominees for the two positions are he and J. David Nagel, M.D. He asked if there were any other nominations for the office. Carol W. Garvey, M.D., was nominated. There were no other nominations for this office and the nominations were closed.

Dr. Snyder said for the position of AMA alternate delegate January 1995 through December 1996, the nominee

was Jose M. Yosunico, M.D. He asked if there were any other nominations for the office. The following nominations were made: Paul A. Stagg, M.D., Donald H. Dembo, M.D., and Joseph Fastow, M.D. There being no further nominations, the nominations were closed for this office.

The chairperson referred to the bylaws and noted that the ballot could be dispensed with by unanimous consent for the uncontested positions. It was moved to dispense with the vote for the uncontested positions. The motion was seconded and approved by the House.

At this time nominating speeches were presented; speeches were made for the nominees for the AMA delegate positions first. Carol W. Garvey, M.D., spoke on her own behalf. Alex Azar, M.D., spoke on behalf of J. David Nagel, M.D. Joseph Snyder, M.D., spoke on his own behalf.

The chairperson then called for the speeches for AMA alternate delegate positions. Donald H. Dembo, M.D., spoke on his own behalf; Allan D. Jensen, M.D., spoke on behalf of Joseph Fastow, M.D.; Alex Azar, M.D., spoke on behalf of Paul A. Stagg, M.D.; and Hiroshi Nakazawa, M.D., spoke on behalf of Jose M. Yosunico, M.D.

Dr. Lilly thanked the House for its vote of confidence.

❖ *Treasurer's report*

Carol W. Garvey, M.D., presented the treasurer's report and said House members had the revised 1993-1994 budget in their packets. Med Chi's financial statements, as of December 31, 1992, were audited last fall by Naden Lean, and Med Chi again received an unqualified opinion on the financial statement—the highest opinion that can be expressed by a CPA firm. Preliminary work had been started on the December 31, 1993, audit, the results of which will be available in the fall.

Dr. Garvey said Med Chi's peer review and physician rehabilitation programs were subjected to performance audits by the state legislative auditors last fall, which covered the period from August 1, 1991, until July 31, 1993. After spending over 300 person days at Med Chi in a vigorous effort to detect some evidence of waste, abuse, or fraud, the auditors found no significant problems. Dr. Snyder sent a letter to the governor as well as to the state officials who directed the audit. The governor replied that the auditors may have overstepped their bounds.

Dr. Garvey said Med Chi is in the process of updating its equipment. A new telephone system was recently installed and Med Chi has contracted for networking of all Med Chi computers and has purchased new software for accounting, membership, and convention functions. It was noted that under the leadership of the chief operating officer and the new comptroller, Med Chi has reorganized and updated its financial records.

Dr. Garvey said the Council passed a resolution earlier on this day recommending a dues increase to the House. Med Chi last increased its dues in 1979, and its dues are lower than any other state. Dr. Garvey said that at the September House meeting in Ocean City, a preliminary 1995 budget should be ready for presentation and a specific proposal for the size of the dues increase should be available at that time.

A question arose about a deficit showing on the budget and the \$598,000 physician rehabilitation money included in it. Dr. Garvey said a cushion of \$200,000 had been built into the budget in case of a deficit. This year's budget is more comprehensive. It was noted that the 1993 and 1994 budgets were not comparable.

❖ *Report of Council*

Allan D. Jensen, M.D., Council chairperson, received approval from the House to dispense with the reading of the list of emeritus members as submitted by their component societies and sent to the House. The House granted emeritus membership to the following:

Affiliate:

John W. Heisse, M.D.

Pedro Fonseca, M.D.

Allegany County:

Nicholas Giarritta, M.D.

Lesllie L. Mould, M.D.

Clinton Rogers, M.D.

Anne Arundel County:

Anna M. Bryan, M.D.

Michael B. Monias, M.D.

Baltimore City:

Victor Albites, M.D.

Gerald J. Carroll, M.D.

Hilbert M. Levine, M.D.

George H. Miller, M.D.

J. Rollin Otto Jr., M.D.

Herbert L. Yousem, M.D.

Baltimore County:

George A. Abeshouse, M.D.

John J. Darrell, M.D.

D.V. Jezic, M.D.

John J. Messina, M.D.

James E. Taylor, M.D.

Donald O. Wood, M.D.

Carroll County:

Naci N. Buyukunsal, M.D.

Howard County:

Robert Herman, M.D.

Marston A. Young, M.D.

Montgomery County:

Wyarth P. Baker, M.D.

John C. Devers, M.D.
 Raymond J. Gibbons, M.D.
 Michael S. Madeloff, M.D.
 Howard I. Passes, M.D.
 Donald Straus, M.D.
 J. Richard Thistlethwaite, M.D.
 Thomas G. Ward, M.D.
 Mitchell Woldoff, M.D.

Prince George's County:

Raymond Parisi, M.D.
 Mozayan Aladj, M.D.

Washington County:

George Milic, M.D.

Wicomico County:

Edmond J. Fleming, M.D.

Dr. Jensen said the House had been provided with a list of members whose names were submitted by their component medical society for a waiver of dues and asked that the House dispense with the reading of the list. There being no objection, the House dispensed with the reading of the waiver of dues list.

Dr. Jensen asked the House to grant a waiver of dues to those members whose names were presented and the House approved the waiver of dues for the following members:

Baltimore City:

Patricia A. McIntyre, M.D.

Baltimore County:

Lilia Ceballos, M.D.
 Robert Gattuso, M.D.
 Hernando Pava, M.D.
 David Roberts, M.D.
 Robert Stoltz, M.D.

Montgomery County:

Norman R. Bishop, M.D.
 Debra Chester Kalter, M.D.

❖ *Retreat Committee report*

Allan D. Jensen, M.D., chairperson of the Retreat Committee, said the Council accepted the Retreat Committee's report with one amendment and that he had been asked to bring the report to the House. Dr. Jensen reviewed the background of the Retreat Committee—how it was formed, why it was formed, membership, etc. He drew the House members' attention to the Retreat Committee report that was included in their packet. He suggested approval of the mission statement as presented by the Bylaws Committee because it provided greater focus and clarity and reported that the Council had accepted this mission statement. Dr. Jensen said the Retreat Committee had proposed the enact-

ment of new bylaws to streamline the organizational structure.

Dr. Jensen then said the Council approved the proposed bylaws of the Retreat Committee. He said the Retreat Committee's bylaws differed slightly from the Bylaws Committee, which had been sent to all House members, and would be presented later by the Bylaws Committee. He said the bylaws presented by the Bylaws Committee are 99% similar and the Retreat Committee is anxious for the House to accept the Bylaws Committee's recommendations.

Dr. Jensen then referred to the recommendations of the Retreat Committee, which included a job description for the chief executive officer, with the establishment of performance criteria and regular evaluation and feedback processes; measures to reduce political infighting; measures to enhance the role of component and specialty societies; and the creation of a means to identify and address issues critical to the success of Med Chi in a more effective and timely manner. Dr. Jensen stressed a need for improved communications, more effective inclusion of physicians from all geographic areas and specialties, and continuous monitoring of Med Chi's performance and regular consideration for suggestions for improvement. Dr. Jensen said the Council recommended accepting the report of the Retreat Committee with the single amendment and the suggestion that there should be a new set of bylaws with the above recommendations as noted. The chairperson thanked Dr. Jensen for his report.

❖ *Bylaws Committee report*

The chairperson said the House had been mailed the bylaws report with 17 items to be addressed. The chairperson asked J. Ramsay Farah, M.D., chairperson of the Bylaws Committee, to present his report.

Dr. Farah certified that the bylaws were mailed as required by the present Med Chi bylaws. Dr. Farah recommended adoption of the bylaws as recommended by the Bylaws Committee.

Dr. Farah said there was a list of editorial changes to the bylaws (spelling errors, typos, etc.) that did not change the meaning of the bylaws. Dr. Farah asked that the editorial changes be accepted.

Dr. Farah informed the House that the proposed bylaws were in harmony with all of the other societies and with the AMA. He moved for consideration of the revised bylaws as a whole and the adoption of the revised bylaws.

The chairperson said that since these were committee recommendations, they did not need to be seconded. It was noted that the first motion was to consider the revised bylaws as a whole. Hilary T. O'Herlihy, M.D., speaking as chair-

person of the Small Component Caucus, said the Small Component Caucus recommended adopting the bylaws as a whole. He called for the question. The chairperson said there had not been enough discussion on the matter.

Thomas E. Allen, M.D., speaking on behalf of Baltimore County, commended the Bylaws Committee on its outstanding job, and also commended the Retreat Committee. Dr. Allen said Baltimore County noted minor problems and requested that certain items be extracted. He said Baltimore County was concerned with the sections regarding the speaker and the vice-speaker of the House of Delegates not serving with a vote on the board of trustees.

The chairperson said this was an important issue, but that the actual board of trustees would not meet for another year. Dr. Snyder said the Executive Committee will serve as the board of trustees and the chairperson and vice-chairperson of Council will become the speaker and vice-speaker.

Dr. Jensen said the proposed bylaws had been reviewed by the Retreat Committee, the Bylaws Committee, the Policy and Planning Committee, and the Executive Committee and they all had given their approval. Dr. Jensen said he spoke to the motion to pass the bylaws as a package and that everyone recognized that a meeting would be held in July. He said that at that time recommended amendments with 30 days' notice could be sent out for everyone to consider.

Frederick Hatem, M.D., objected to the haste with which the House was changing the governmental structure of Med Chi. He said the new structure would basically disenfranchise large areas of the state, which are made up of the smaller components and further put the upper echelon farther from the individual physician, and as such would further discourage membership. Dr. Hatem said if the new bylaws passed, there would be no Council and Med Chi would no longer get members such as Drs. Lewers, Azar, Fastow, and Stagg, who have become leaders of Med Chi. Dr. Hatem said he was speaking against the motion.

Gary Rosenberg, M.D., also spoke against the motion. He was concerned about how the Nominating Committee was constituted and that it should be elected and not chosen by the board of trustees. He said this would be a way of making Med Chi truly democratic.

Dr. Snyder said the nominating process would not take place until after the next two meetings of the House of Delegates. Therefore, there was time for the Bylaws Committee to fine-tune the bylaws.

J. David Nagel, M.D., asked for an explanation of what would happen if everyone voted "yes." The parliamentarian said they would be voting to vote on the bylaws as an entire package. He also said a two-thirds vote was needed to pass the revised bylaws. That would be the second motion.

Dr. Nagel spoke in favor of passage with extractions.

Dr. Malouf said every county was represented on the Retreat Committee. He said all points were brought up and many of the issues currently being raised were fully addressed at the Retreat Committee. Dr. Malouf said there was a general feeling now that Med Chi needs to streamline what it is doing. He said there would be time to fine-tune the bylaws and urged the House to adopt them.

Dr. Allen said Baltimore County was withdrawing its motion to extract items from the bylaws and was supporting the motion.

Dr. Dembo said this was a major step in making the organization effective. He said if one compared the proposed bylaws with what exists in the organization, not one person would vote against the bylaws. He assured the House that changes could be made to the bylaws if they are approved. He said this would be a grassroots organization.

Dr. Nagel called the question. Dr. Snyder said the first motion was for consideration of the bylaws as a whole. The House of Delegates voted to consider the bylaws as a whole.

Dr. Snyder said the House would vote on the bylaws as presented by the committee, which he said required a two-thirds vote. The question was called. Dr. Snyder asked if the House approved the question to be called. The House approved the calling of the question. Dr. Snyder said the motion was on the approval of the bylaws as presented by the Bylaws Committee. Dr. Snyder asked all in favor to stand. The House approved by a majority vote.

Dr. Lewers asked for a point of personal privilege. He said every president since 1982 had asked that new bylaws be drafted. He thanked and congratulated the House.

Dr. Farah said the Bylaws Committee recommended the following:

- ♦ that it continue work on developing the rules of Med Chi to effect an orderly transition;
- ♦ that the structure of the Councils (as suggested by the Bylaws Committee) and the concept of a rules and regulations committee be approved; and
- ♦ that the specialty societies begin to take immediate steps to form their own section.

As a point of order, Dr. Farah noted that elections should be held to fill the vacancies that *may* exist on the board of trustees.

Dr. Dembo said there should be a rules committee to address the rules, but did not think it necessary to assign the development of the rules to a specific committee.

Dr. Farah said that the way the Retreat Committee presented the councils, a rules committee was not included. Therefore, there was a need to include a rules committee.

Dr. Farah said he wanted to ensure that a rules committee was formed.

Dr. Snyder called a vote on the recommendations of the Bylaws Committee. The House approved the recommendations of the Bylaws Committee. Therefore, in addition to the bylaws, the following recommendations also were approved:

- ♦ that the Bylaws Committee continue to work on developing the rules of Med Chi to effect an orderly transition;
- ♦ that the structure of the councils (as suggested by the Bylaws Committee) and the concept of a rules and regulations committee be approved;
- ♦ that the specialty societies begin to take immediate steps to form their own section; and
- ♦ that elections be held to fill the vacancies that may exist on the board of trustees.

❖ *Ad Hoc Committee for Establishing an IPA*

Allan D. Jensen, M.D., chairperson of the Ad Hoc Committee for Establishing an IPA (independent practice association), presented the committee's report. He said the committee was created by the Executive Committee after it noted a great influx of managed care organizations being created in Maryland and recognizing that many of them were hospital dominated. Also, members were asking what Med Chi was doing for its members. The committee sent out requests for proposals. Two organizations that gave proposals said they could start an IPA for Med Chi; however, one group said they were not sure this was the right thing to do. This group, the Eastwest Research Corporation, was hired. Dr. Jensen said there was some concern by the committee that members would view sponsoring an IPA as competition. He also said an IPA is frequently exclusive. Also, it has been said that 80% of IPAs are going to fail.

Dr. Jensen introduced David Berman and Mary Ellen Michels of Eastwest Research Corporation. The consultants handed out a report, which they then discussed. They said Med Chi's goal was to develop a managed care strategy that offers alternatives to members, includes all interested physicians, and succeeds in the market. They said the Eastwest approach would be to develop a viable managed care strategic plan during Phase I; to create an implementation plan and budgets during Phase II; and to implement strategy during Phase III. They said the report being presented was Phase I.

Mr. Berman presented slides on a traditional IPA. He said the ad hoc committee had several recommendations based on the conclusions and findings of Eastwest. Mr. Berman asked Dr. Jensen to discuss these recommenda-

tions. Dr. Jensen said this committee represented physicians with a broad knowledge of the managed care issues and also numerous geographical areas. Members included:

Thomas E. Allen, M.D.
 Thomas DeMarco, M.D.
 Donald H. Dembo, M.D.
 Michael Dobridge, M.D.
 Michael Epstein, M.D.
 Carol W. Garvey, M.D.
 Arthur Keefe, M.D.
 Allan Leffler, M.D.
 Arnold Levy, M.D.
 J. Richard Lilly, M.D.
 Francis Mayle, M.D.
 George Malouf, Sr., M.D.
 Joseph Snyder, M.D.
 Gerald Winnan, M.D.

Dr. Jensen said they reviewed Eastwest's report very carefully and concur with the following recommendations:

Med Chi should create a new entity for managed care contracting. It would be similar to Med Chi Agency in that it would be part of Med Chi, but separate from Med Chi. The new entity should develop a statewide network linking individual physicians with IPAs and physician components of PHOs. Applications should be sent to all members and organizational applications would be sent to all IPAs. Physicians may contract independently or through an IPA. Where appropriate, out-of-state relationships would be established.

The entity would market to HMOs, PPOs, insurers, and self-funded employers and unions on both a statewide and regional basis and the payors could select subsets and would acquire managed care services to support the IPA/PHO operations. The entity should evaluate managed care plans and sponsor more managed care physician education. The entity would also solicit the involvement of all member physicians and consider the development of regional offices.

Dr. Jensen said the committee recommended that everything be considered as a package.

Dr. Snyder said the question was on the committee's recommendation. Discussion ensued regarding such an IPA. The Eastwest consultants were asked whether they were forming a cartel and what their experience had been in other states. Mr. Berman said Eastwest is aware of the Connecticut IPA, which was started about 10 years ago and is doing well. Regarding whether they were creating a cartel, Mr. Berman said he was not an attorney, but he hoped they would be so successful that they would be sued over whether or not they were a cartel. Mr. Berman said such an entity is at risk, but as soon as the risk is assumed, a lot of

the antitrust issues go away. He also said the fact that the new entity will be at risk does not mean that Med Chi will put individual physicians at risk.

Donald W. Mintzer, M.D., questioned who was going to pay to establish an IPA. Dr. Mintzer moved to table the motion until a later date. The motion was not seconded and it therefore failed.

Daniel Kohn, M.D., said Med Chi strategy should be primary-care oriented and suggested that the words "at this time" be added to that recommendation. Mr. Berman agreed.

Michael Dobridge, M.D., a member of the committee, spoke in favor of moving ahead. Frederick Hatem, M.D., seconded Dr. Dobridge's recommendation. Dr. Hatem said such a move has the potential for being one of the most important actions Med Chi is taking.

Dr. Hatem moved to proceed with the necessary activities to implement an IPA. Dr. Snyder said the committee had already made that recommendation.

Alex Azar, M.D., speaking in favor of the motion, said a new organization, the Maryland Healthcare Consumer Alliance, Inc., made a presentation to the Health Care Access and Cost Containment Commission. This coalition of major large businesses and labor in Maryland wants to negotiate a pool of purchasers to bring about a provider implementation of integrated health care and delivery networks, establish a fixed price for three years with no inflation, and negotiate reduced costs. The alliance includes the Maryland Teacher's Association, the AFL-CIO, and Baltimore Gas and Electric Company. Dr. Azar said he told coalition members that Med Chi is setting up a network and they stated they would "be more than happy to sit down and negotiate a deal" with Med Chi. Dr. Azar said they are willing to talk and that BlueCross BlueShield also wants to get into such a type of relationship. He concluded by urging the House to move forward as rapidly as possible.

Albert Blumberg, M.D., spoke in favor of the committee's report, saying it was an urgent need. Dr. Blumberg asked what would be the cost of the new entity and how it would be paid.

Mr. Berman said that if Med Chi wanted to build or buy some of the services, it would be more than if the services were rented. It would cost from \$1 million to \$10 million. Dr. Blumberg asked how they were planning to raise this amount of money. Mr. Berman did not believe Med Chi should look toward venture capital because such funds usually come with strings attached. However, money for setting up a venture could be attained by assessing members, through commissions, etc. Dr. Blumberg said that if each physician was assessed \$200, Med Chi could have \$1

million; therefore, it can be done if people are committed. Mr. Berman said that basically Med Chi would be selling physician access. He said such an entity could give the same type of cost performance and controls as some of the closed systems, while giving both patients and physicians more choice.

The question was called. The House approved the calling of the question. The House then voted on the committee's recommendation that Med Chi create a new entity for managed care contracting. The motion passed.

Dr. Malouf and Dr. Snyder urged that a letter be sent immediately to members letting them know of the House's vote on this matter.

❖ *Adjournment*

There being no further business, the meeting was adjourned at approximately 5:45 p.m. Dr. Snyder reminded the House that there would be a general membership meeting following this meeting for members.

Respectfully submitted,
SECRETARY PAULA A. STAGG, M.D.

□ □ □



DONALD H. DEMBO, M.D., with his wife, Libby, is SWORN INTO THE MED CHI PRESIDENCY by OUTGOING PRESIDENT JOSEPH SNYDER, M.D.

Hospital Medical Staff Section 24th Assembly Meeting December 1-5, 1994 Sheraton Waikiki Hotel Honolulu, Hawaii

Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses;
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

Plan to participate in the Federation Consortium on Friday, December 3 from 2:30 to 5:30 pm in Honolulu, Hawaii. MahaIo!

American Medical Association
Physicians dedicated to the health of America



COMING OUT OF THE DARK

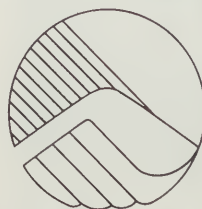
Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families.

The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

Medical
and Chirurgical Faculty
of Maryland



**Physician
Rehabilitation
Committee**

Minutes of the House of Delegates—343rd Session—May 14, 1994

❖ *Members, guests and staff present*

The attendance list was submitted to all House of Delegates members. The roster is on file in the Med Chi executive department.

❖ *Call to order*

The 343rd session of the House of Delegates was called to order by the president, Joseph Snyder, M.D., at 2:15 p.m. in the Ramada Inn and Convention Center in Hagerstown, Maryland.

❖ *Visiting dignitaries*

The chairperson acknowledged the visiting dignitaries from surrounding states and recognized the presence of Ted Lewers, M.D., a Med Chi member and an AMA board of trustees member. Dr. Lewers noted that it was a privilege to be able to be in attendance. Dr. Lewers said the AMA delegation worked tirelessly for him when he was running for the AMA board of trustees. He said it was the hard work of Med Chi, the AMA delegation, and the alliance that got him elected.

❖ *Special recognition*

J. David Nagel, M.D., asked and received a point of personal privilege to ask the House to pay a vote of gratitude to John H. Hebb, M.D., for his long years of service on the AMA delegation. He said Dr. Hebb was elected over 15 years ago to serve as an alternate delegate to the AMA, has taken to the AMA meetings the voice of medicine in Maryland, and has been a gentleman and a professional all the time. Dr. Nagel concluded by stating that Baltimore County, the AMA delegation, and the House saluted him. Dr. Hebb thanked the House, stating he has enjoyed working for the AMA and for Med Chi and he knew that the people following him would do well.

❖ *Board of Physician Quality Assurance*

Israel Weiner, M.D., chairman of the Board of Physician Quality Assurance (BPQA), presented its report to the House. Dr. Weiner said the BPQA was concluding its sixth year since it was established by the General Assembly in 1988. Approximately 21,000 physicians are licensed, and approximately 15,000 practice in Maryland. BPQA also licenses and certifies 561 unregistered medical practitioners, residents, and fellows, who must be registered with the

BPQA, but are not licensed. BPQA also licenses and certifies over 8,000 allied health practitioners, including physician assistants, paramedics, and x-ray and respiratory technicians. Dr. Weiner said BPQA is finally getting the licensure process computerized to improve the speed of reaction.

Dr. Weiner said that during the past five years, the number of formal actions taken by BPQA went from 29 to 61 to 73 to 113 and last year, 135. Dr. Weiner said that each year the Federation of State Medical Boards ranks the state according to the number of actions per 1,000 licenses. He said that in the past four years, BPQA has gone from 49th in the country to 42nd to 27th and last year, 14th. He said the goal is to get into the top ten, which he said is very difficult for a small state with a large number of physicians.

Dr. Weiner said the renewal process has been streamlined and BPQA has tried to speed up and streamline the investigative process. Last year, 83% of the complaints were resolved within 12 weeks. Physicians are given three weeks to reply to a complaint.

BPQA has had legislative success during the past session. Dr. Weiner said it is doubtful that physician assistants will be allowed to write therapeutic orders. BPQA is working on this issue and will come to Med Chi with some possible ways around that problem. He also said the acupuncture law was modified. Acupuncture was the only procedure that a physician had to receive dispensation from the BPQA to perform. Now physicians wanting to do acupuncture can do so under the supervision of the BPQA. Non-physician acupuncturists are under their own board. However, physicians cannot call themselves acupuncturists; they can say they practice acupuncture.

Regarding peer review, Dr. Weiner said that, after receiving a complaint, it can be difficult to know whether the patient or the physician is correct. These are the two types of issues that are referred to the peer review committees. Dr. Weiner thanked the four large components—Baltimore City, Baltimore County, Montgomery County, and Prince George's County—for the work they have done in the medical review process, as well as the work done by Med Chi. Noting that peer review is an educational process, Dr. Weiner said BPQA is looking at CME credits for participation in peer review and encouraged all the physicians to volunteer for peer review. The work is time-consuming and difficult; BPQA therefore hopes to reward physicians in the future with CME credits.

❖ *Election results*

For AMA delegate, the House elected Joseph Snyder, M.D., and J. David Nagel, M.D. Both Drs. Snyder and Nagel thanked the House for their support.

On the first vote, to fill one of the two positions of alternate delegate, Donald H. Dembo, M.D., was elected. It was noted that another ballot was needed. The remaining candidates for the second ballot were Joseph Fastow, M.D., Paul A. Stagg, M.D., and Jose Yosunico, M.D. Delegates were allowed only one choice. No one received a majority of votes after the second ballot for alternate delegate and the name of Paul A. Stagg, M.D., was dropped because he had the least votes. On the third ballot, Jose Yosunico, M.D., was elected to fill the other vacant position.

❖ *Alliance report*

Georgia Lizas, president of Med Chi's Alliance, presented its report, noting that the alliance had had a very successful year and that its name had been changed yesterday (May 13, 1994) from the auxiliary to the alliance. She reported the following accomplishments:

- ♦ Anne Arundel County Alliance, along with the medical society, had the very first mini-internship in Maryland, in which a member of the community accompanies a physician for a day to see what a difficult job a physician has.
- ♦ Ten billboards regarding breast cancer awareness were put up around the state.
- ♦ Money was given to the mammography mobile unit in Baltimore so that underprivileged women had the opportunity to get a mammogram.
- ♦ Counties around the state invited knowledgeable speakers to their meetings to keep them updated on legislation.
- ♦ The alliance sponsored a "Day in Annapolis" and members were able to meet with many of the members of the General Assembly.
- ♦ The alliance donated money to the Frederick County Hospice so that it could rent an oxygen tent for the year to have it on hand for emergencies.
- ♦ Many programs were held throughout the state to raise money for the AMA-ERF programs.
- ♦ A computer was given to the Hartley House in Frederick, a home for domestic violence victims.
- ♦ The alliance worked with the Network Against Domestic Violence helping to create a poster encouraging victims of domestic violence to seek help. The posters were to be placed in physicians' offices and hospitals throughout Maryland.

Dr. Snyder thanked Mrs. Lizas for doing an effective job as alliance president and said it had been a pleasure to work with Mrs. Lizas during the year. A certificate of appreciation was presented to Mrs. Lizas.

❖ *Maryland Medical Political Action Committee*

The chairperson recognized Frederick Hatem, M.D., chairperson of the Maryland Medical Political Action Committee (MMPAC), for the committee's report. Dr. Hatem said that during the last four years, membership in the MMPAC had dropped 35%. Membership increased about 10% during the past year and reached 81% of the goal set by the American Medical Political Action Committee (AMPAC). Maryland is the sixth highest state percentage-wise according to AMPAC's figures. MMPAC has had a successful year. It is an independent organization that exists to further the legislative and political aims of the medical society. This can only be done with cooperation from the members of the society and the staff. Dr. Hatem thanked all members of the staff, Angelo J. Troisi, F.A.C.H.E., chief executive officer; Rose M. Matricciani, R.N., J.D., chief operating officer; Angus Everton, Esq., general counsel; Jennifer Odenwald, legislative assistant; and Jay Schwartz, Esq., lobbyist.

❖ *New business*

a. Resolution to promote antiviolenence. Donald H. Dembo, M.D., presented a resolution to the House as requested by Thomas E. Hobbins, M.D., a member of the Baltimore Physicians for Social Responsibility. The resolution deals with guns being turned in for teddy bears. Dr. Hobbins is asking for the House to approve the concept of removing useless guns from the streets in exchange for teddy bears. Dr. Dembo said he would like to move that Med Chi support the concept of removing useless guns from the streets in exchange for teddy bears.

Dr. Snyder said the vote would have to be approved by two-thirds of the House to be discussed. Dr. Snyder said a vote of approval was needed. The motion was approved.

Dr. Dembo said the motion was that Med Chi join hands in the effort to promote antiviolenence. It was moved to approve the resolution. There was a unanimous vote to approve the resolution.

b. Babysitting for meetings. Carol Plotsky, M.D., delegate from Montgomery County and a pediatrician, whose husband is also a delegate, said she was concerned that there was no child care provided at Med Chi meetings. She said

she will make it a formal resolution if it is approved by the House that child care be made part of Med Chi meetings. She said it has been difficult for her and her husband to attend these meetings. Dr. Plotsky said younger members would be willing to attend Med Chi meetings, and to bring spouses if they are not currently delegates also, if they could have their children taken care of as a part of the meeting. Dr. Plotsky requested that the House agree to a motion to have babysitting included as a part of the meetings. Dr. Snyder noted that unless there was objection, the staff of Med Chi would look into this matter for the next meeting. Dr. Snyder said he thought it was a good idea. Dr. Snyder said that it was so moved.

Marianne Benkert, M.D., moved that Med Chi see that child care is provided onsite for the annual and semiannual meetings. The motion was seconded. The House approved the motion.

It was noted that there would now be four House of Delegates meetings per year and that the motion should have been for four meetings, not two. Dr. Snyder said it will be for whatever meetings that Med Chi has of the House of Delegates and assured the House that that will be corrected.

❖ *Outgoing president's remarks*

Dr. Snyder said that during the past year, he had the honor to represent Med Chi members throughout the state, at other states' functions, at AMA meetings in various states, and at various leadership conferences. He had the opportunity to participate in deliberations about the problems in health care reform. He said he tried to represent Med Chi members to the best of his ability. He thanked the House for electing him and offering him their trust to serve.

Dr. Snyder then thanked the staff and said that without the staff of the society he could not have functioned. He recognized Angelo J. Troisi, F.A.C.H.E., CEO; Rose M. Matricciani, R.N., J.D., COO, Ruth Seaby, director of communications; Vivian Smith, assistant director of communications; Angus Everton, Esq., general counsel; Debra Sciabarrasi, administrative assistant to the CEO; and Arlene Whalen, administrative coordinator to the COO.

Dr. Snyder concluded by noting that he would not have been able to handle the duties of the presidency without the help of his best friend, his wife Madrian.

❖ *Oath of office*

The president, Joseph Snyder, M.D., asked the president-elect, Donald H. Dembo, M.D., and his wife, Libby, to come forward. He then swore in the new president and presented the president's medallion to Dr. Dembo, as well as the gavel,

which signifies the change of the presidency. Dr. Dembo presented the past president's medallion to Dr. Snyder.

❖ *Incoming president's remarks*

Dr. Dembo said that a year ago, the House of Delegates, representing a frustrated membership, said "no" to politics as usual, to political bosses, to dictatorial decision making. He said the members were tired of apathy, of a posture of reacting rather than being proactive, and members said "no" to the acceptance of defeat when Med Chi members did not rise to the challenges that faced them. Dr. Dembo noted that members said they cared about issues.

Dr. Dembo said that when he was elected, the right to say no by members was exercised. He said that members challenged him to make a difference by stating that physicians must structure health care reform, must dictate practice, and must be patient advocates. He said that it would not make any sense for anyone but physicians to structure the health care system. He said the reconstruction of the health care system is the largest challenge physicians have ever faced.

Dr. Dembo said Med Chi will revisit the issue of free-standing facilities, press for a role for Med Chi in some form of a statewide IPA, push at both the state and federal levels for relief from antitrust, and improve the communications of Med Chi so Med Chi can be a grassroots organization that responds to the needs of the public.

Dr. Dembo said the most important job for Med Chi during the year would be implementing a new governance that will make Med Chi more efficient and better. He said that when members disagree, they must recognize there is a democratic process and the majority will rule. He said members should discuss their differences and try to reach consensus and compromise where appropriate. He stressed that with 7,000 members, Med Chi is the only organization that can speak authoritatively for physicians and patients.

Dr. Dembo said that with the membership's help he would not be their leader, but their servant in helping Med Chi become the most highly respected organization in Maryland and serve as a model for the nation. He said the presidency of the organization was the greatest honor of his career. He singled out his wife as the person who has helped him achieve goals in his life.

❖ *Adjournment*

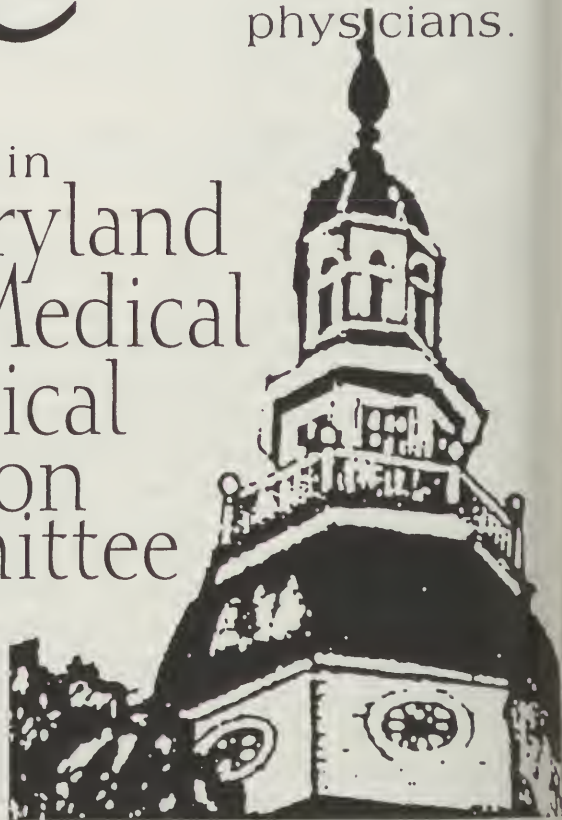
There being no further business, the meeting was adjourned at 5:10 p.m.

Respectfully submitted,
SECRETARY PAUL A. STAGG, M.D.

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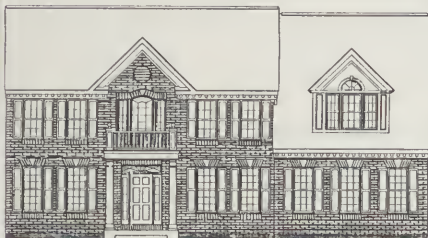


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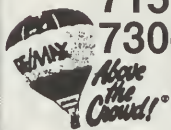
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Addictions Committee

Mr. President and Members of the House of Delegates:

With the increasing focus over the last couple of years on tobacco and other addictions, the Committee on Alcoholism and Chemical Dependency pursued a change in its name this year to one that more generally reflects its purview. The name *Addictions Committee* was unanimously agreed upon by members, later approved by the Council, and ultimately made official at the 1994 Med Chi annual meeting.

During the past year, the committee continued its efforts toward raising awareness about alcohol, tobacco, and other drug abuse. Specifically, the committee took an interest in the coverage of these illnesses in state and national health care reform plans. The gathering of pertinent factual information was a primary focus and the committee vocalized to the Med Chi Executive Committee its support for parity substance abuse coverage in HB 1359, Maryland Small Employer Health Care Reform. A statement prepared by the committee was forwarded by the Med Chi Executive Committee to the Med Chi Standard Benefits Technical Advisory Committee.

To remain current with the issues of importance to substance abuse in the legislature, the committee began to review bills that were introduced during the 1994 session. The committee reviewed many bills and actively voiced its opinions regarding substance abuse and addiction-related issues. The committee took several issues before the Med Chi Executive Committee, requesting support for specific pieces of legislation that would further the cause of increasing awareness of substance abuse, prevention, education, and the need for adequate care for those suffering from addictions. As in previous years, the committee's focus on the dangers inherent in tobacco use continued with its support of most bills sponsored by The Coalition for a Smoke Free Maryland.

Since early 1994, the committee has acted as Med Chi's representative to the Maryland Addiction Recovery Coalition, a coalition of organizations that have come together to advocate for better coverage and resources for substance abuse treatment.

The tobacco advertisement warning labels developed by the committee during the 1992-1993 year, in cooperation with the Physician Rehabilitation Committee, have remained available to physicians. The committee was impressed by a presentation from Med Chi staff who manage

the Med Chi Substance Abuse Education for the Primary Care Physician project and was able to provide some feedback.

Peter Beilenson, M.D., M.P.H., commissioner of health, Baltimore City Health Department, also presented briefly to the committee in April on treatment issues in Baltimore City and the recommendations of the Mayor's Working Group on Drug Policy Reform. The committee has requested another visit in the near future with Dr. Beilenson to allow an open dialogue on these issues and to evaluate ways Med Chi can assist in finding solutions to the huge challenge that addictive diseases present to urban areas.

In addition to its goal of remaining active in monitoring legislation that affects the addicted, the committee is planning a group of articles for an issue of the *Maryland Medical Journal* on addictions. Furthermore, the committee hopes to sponsor presentations at future Med Chi meetings and will co-sponsor the Fifth Annual Conference on Addiction with the Physician Rehabilitation Committee.

Committee members

Chairperson Patricia A. McIntyre, M.D.
C. Alex Alexander, M.D.
Leroy C. Bell, M.D.
Jonathan Book, M.D.
Franklin T. Evans, M.D.
Beadia H. Hill, M.D.
John H. Hirschfeld, M.D.
Isadore Kaplan, M.D.
Christie G. Lamping, M.D.
Dan H. McDougal, M.D.
David R. McDuff, M.D.
Abraham M. Schneidmuhl, M.D.

Advisory members

Patricia Miedusiewski, R.N.
Ludwig L. Lankford
Phil McKenna
W. Robert Miller
Philip P. Nolan, D.D.S.

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Committee on AIDS

Mr. President and Members of the House of Delegates:

During the past year, the Committee on AIDS (acquired immunodeficiency syndrome) continued to review legislation and proposed regulations on issues surrounding AIDS. It supported the recommendation of the Immunizations and Infectious Diseases Subcommittee opposing the 14-digit unique identifying number for patients tested for HIV infection or CD4+ lymphocyte count as the code was determined to be unworkable, too time-consuming, and unwieldy. On October 26, 1993, Med Chi submitted testimony supporting the efforts of the Department of Health and Mental Hygiene to increase funding, improve statistical analyses, and provide educational and prevention services, but not supporting use of a 14-digit identifying code. The proposed regulation has since undergone revision and appears in the *Maryland Register*. Public comment and testimony will be heard again on the revised version of the regulation.

The committee also sponsored a continuing medical education activity, in conjunction with the Women in Medicine Committee and the Immunizations and Infectious Diseases Subcommittee of the Committee on Public Health, at Med Chi's 1994 annual meeting entitled, "AIDS Awareness and Detection: Adolescents, Women and Young Adults." Margaret T. Snow, M.D., chairperson, Committee on AIDS; Robert J. Ancona, M.D., chairperson, Immunizations and Infectious Diseases Subcommittee of the Committee on Public Health and chief, department of pediatrics, Union Memorial Hospital; Stanley L. Blum, M.D., chief, division of otolaryngology, North Arundel Hospital; and Jean Anderson, M.D., assistant professor, department of obstetrics and gynecology, Johns Hopkins University School of Medicine, served as speakers. The program's aim was not only to explain recent advances in evaluation and treatment of HIV-positive patients and patients with AIDS, but to improve the physician's ability to recognize the manifestations of undiagnosed HIV, particularly in women and young people, and to educate physicians about the importance of specialist involvement in the treatment of HIV-positive patients and patients with AIDS. The program was deemed a success as it was very well received by those in attendance.

Committee members are still interested in the idea of sponsoring a basic AIDS education (AIDS 101) program for

Maryland's senators and delegates and their staff. The intent would be to present scientific information on prevention, control, and the treatment of AIDS. The committee is also interested in pursuing the idea of a special issue of the *Maryland Medical Journal* on the subject of AIDS.

Committee members

Chairperson Margaret T. Snow, M.D.
Carla Alexander, M.D.
Robert J. Ancona, M.D.
Randy Berger, M.D.
Stanley L. Blum, M.D.
James E. Bowes, M.D.
John C. Downs, M.D.
Andrew P. Fridberg, M.D.
Kathleen Harrison, M.D.
John M. Henderson, M.D.
Bernard McGibbon, M.D.
Janet L. Rice, M.D.
John R. Warfield, M.D.
David Wheeler, M.D.
Jack Zimmerman, M.D.

Advisory members

Kathleen F. Edwards, Ph.D., R.N.
Eric Fine, M.D.
Joyce Harper, M.D.

Alliance member

Mrs. Claire Jensen

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Ad Hoc All Payor System Committee

Mr. President and Members of the House of Delegates:

As a result of a resolution before the House of Delegates at its annual meeting in 1993, an ad hoc committee was created to study the feasibility of an all payor system in Maryland.

The members of the Ad Hoc All Payor System Committee first met on December 1, 1993, to review its proposed mission and how best to carry that out. It was decided that the committee should, after analyzing the issues before it, create a questionnaire to be submitted to Med Chi members to determine the membership's general opinions, first, as to its satisfaction with current methods of reimbursement, and second, its willingness to consider various types of all payor or single payor methods of reimbursement.

The first task of the committee was to define the pertinent terms. Initially, it was felt that the term "all payor system" should be defined as a system in which all third party payors pay the same fee to the same entity for the same service. This definition was later refined to read "a payment system whereunder all persons, insurers or governmental payors pay the same amount for each individual medical service to each individual health care provider."

After reaching consensus on other definitions, the committee devoted its meetings to developing and refining the survey questions to be proposed to our membership. On

April 20, 1994, the committee completed the final form of the survey, for submission to the Med Chi Executive Committee for approval. The survey was approved in final form by the Executive Committee on April 21, 1994, and by the time of publication of this report, should have been submitted to selected Med Chi members. Following completion of the survey, the committee believes it will be in a position to transmit these findings to the board of trustees and to make any recommendations that may be appropriate.

Committee members

Chairperson William H. Goldiner, M.D.
Albert L. Blumberg, M.D.
Scott D. Hagaman, M.D.
Edward W. Lampton, M.D.
James F. McMurry, Jr., M.D.
J. David Nagel, M.D.
Ricardo L. Rodriguez, M.D.
Kathleen E. Taylor, M.D.
Robert M. Taylor, M.D.
Alan T. Wright, M.D.

□ □ □

Ad Hoc Bicentennial Committee

Mr. President and Members of the House of Delegates:

The Ad Hoc Bicentennial Committee continued to outline plans for Med Chi's 200th anniversary. An Annapolis venue for the 1999 annual meeting was approved. Since the first meeting was held there in 1799, this will be an appropriate way to celebrate the founding.

We co-sponsored a session at the semiannual meeting with the Library and History Committee. Jane Eliot Sewell, Ph.D., spoke on her work for the history of Maryland medicine book she is researching. An outline and two chapters have already been submitted to the editorial subcommittee of the Library and History Committee.

Finally, we have spoken with *Maryland Medical Journal* staff about a dedicated issue. Although we feel it should have an historical focus, it is also an opportunity to address issues facing medicine in 1999 and the next century.

Committee members

Chairperson Ronald H. Fishbein, M.D.
Federico G. Arthes, M.D.
Emidio Bianco, M.D.
Milford Foxwell, M.D.
Carol W. Garvey, M.D.

COMMITTEE REPORTS

Edward J. Kowalewski, M.D.
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Zorayda M. Lee-Llacer, M.D.
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Hiroshi Nakazawa, M.D.
Guillermo Sanchez, M.D.
Roland T. Smoot, M.D.
Joseph Snyder, M.D.

Paul A. Staff, M.D.
H. M. Zassenhaus, M.D.

Advisory members

Marc Micozzi, M.D., Ph.D.
Philip Teigen, Ph.D., M.L.S.



Bylaws Committee

Mr. President and Members of the House of Delegates:

The Bylaws Committee was given a special charge this year to review the bylaws and mission statement recommended by the Retreat Committee. These bylaws reflected an extensive amount of work by the Retreat Committee to streamline and restructure Med Chi in a manner that would provide for democratic representation, active input from the membership, a sound management structure, and an efficiently run organization.

Input concerning bylaws changes was solicited and provided by individual members and component societies. The committee reviewed all of this information during its meetings and addressed concerns that were expressed.

After a thorough review, open discussion, and lengthy deliberation, the Bylaws Committee prepared recommended bylaws and a revised mission statement for presentation to the House of Delegates for its approval. The changes incorporated by the committee were in the spirit of the recommendations promulgated by the Retreat Committee.

It is with extreme gratitude that the committee wishes to thank the members of the House of Delegates for their support and vote of confidence by adopting these new bylaws and mission statement. In the months ahead, the committee will continue its charge to review the bylaws.

Committee members

Chairperson J. Ramsay Farah, M.D.
Albert L. Blumberg, M.D.
Amy J. Byer, M.D.
Hilda Houlihan, M.D.
Reynaldo L. Lee-Llacer, M.D.
David S. O'Brien, M.D.
Thomas H. Powell, M.D.



Charitable Education Fund Committee

Mr. President and Members of the House of Delegates:

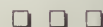
The Charitable Education Fund Committee met twice during the 1993-1994 year to discuss the functions and purpose of these funds. Also of major importance was the preservation of capital and receiving a fair rate of return from our investments. In this ever-changing market, it was decided to make few changes to the investments. The committee agreed to meet on an as-needed basis to address the mission of these funds.

Committee members

President Joseph Snyder, M.D.
Treasurer Carol W. Garvey, M.D.
Secretary Paul A. Stagg, M.D.

Board of Trustees members-at-large

George S. Malouf, Sr., M.D.
J. Richard Lilly, M.D.
Robert B. Goldstein, M.D.



Committee on Computers in Medicine

Mr. President and Members of the House of Delegates:

Ms. Sally Schramm was welcomed as Med Chi's new director of computer services. In this capacity, she initiated the restructuring of the computer system at Med Chi using Novell Netware 3.12 to network the approximately 55 users of the Med Chi system. A new association management software package, purchased through Smith Abbott, Inc., will streamline the association's membership, dues, events management, and accounting functions.

One of the main concerns of the committee is the education of our physicians in the use of computers in their medical practices. A survey done through the *Maryland Medical Journal* showed that the number of doctors using computers is still small. The committee feels that disseminating information is the best way to stimulate the use of this indispensable aid.

We are planning to organize meetings, seminars, and conferences around the state in cooperation with the local physicians. Our first half-day conference was successfully presented at Suburban Hospital in Bethesda on June 4, 1994.

The Med-Sig Bulletin Board remains available to the 640 registered doctors. The upkeep of the database has been curtailed in areas of limited use.

The committee chairperson is a member of the newly formed Medical Database Development Technical Advisory Committee (TAC). The TAC is related to a similar group at the state level, which provides data used in the reshaping of the delivery of health care in Maryland.

Committee members

Chairperson, Dino E. Flores, M.D.

Norman K. Bohrer, M.D.

Manuel S. Cockburn, M.D.

Uwe G. Goehlert, M.D.

Rafael C. Haciski, M.D.

Albert Nahum, M.D.

H.G. Oster, M.D.

William D. Parnes, M.D.

William J. Pogoda, M.D.

Jeffrey C. Schultz, M.D.

Mark S. Seigel, M.D.

□ □ □

Committee on Continuing Medical Education Review

Mr. President and Members of the House of Delegates:

The Continuing Medical Education Review Committee (CMERC) meets six times during the 1993-1994 year. Through authority delegated from the Accreditation Council for Continuing Medical Education (ACCME), the committee surveys and accredits qualified institutions requesting authority to sponsor intrastate continuing medical education activities eligible for Category 1 of the American Medical Association's Physician's Recognition Award. Accreditation benefits both the institution providing educational opportunities and physicians who participate in the activity by ensuring that the educational activities have been developed based on perceived or demonstrated needs, developed with specific educational objectives in mind, and evaluated for their educational value.

The committee's work this year involved:

- ♦ reaccrediting 21 institutions
- ♦ granting initial accreditation to 1 institution
- ♦ reviewing 19 interim reports
- ♦ placing 6 institutions on probation
- ♦ conducting 13 on-site surveys
- ♦ conducting 13 reverse-site surveys
- ♦ providing consultations with numerous sponsors.

The CMERC is also responsible for providing education, guidance, and consultation to accredited institutions as they strive to provide the best possible educational activities for their physicians. To this end, the committee held two workshops for physicians and staff involved with providing

continuing medical education entitled, "Step-By-Step: Documenting Your CME Program." Over 80 individuals attended the workshops, which were held on September 11, 1993, and May 12, 1994. The workshops addressed documentation necessary to demonstrate compliance with the seven "Essentials for Accreditation of Sponsors of Continuing Medical Education" and how to document compliance with the "Standards for Commercial Support of CME."

The committee currently accredits more than 60 institutions, including hospitals, specialty societies, component medical societies, and nonprofit institutions. The following institutions/organizations are accredited by Med Chi to sponsor continuing medical education programs for physicians:

- American Cancer Society - Maryland Division
- American Heart Association - Maryland Affiliate
- American Lung Association of Maryland
- Anne Arundel Medical Center
- Baltimore County Medical Association, Inc.
- Baltimore City Medical Society
- Bon Secours Hospital
- Carroll County General Hospital
- Chestnut Lodge Hospital
- Chartered Behavioral Health System of Maryland at Potomac Ridge
- The Children's Hospital and Center for Reconstructive Surgery, Inc.
- Church Hospital
- Community Psychiatric Clinic, Inc.
- Crownsville Hospital Center
- Doctors Community Hospital
- Dorchester General Hospital
- Fallston General Hospital
- Franklin Square Hospital Center
- Frederick Memorial Hospital
- Garrett County Memorial Hospital
- Good Samaritan Hospital
- Greater Laurel Beltsville Hospital
- Harbor Hospital Center
- Harford Memorial Hospital
- Holy Cross Hospital of Silver Spring
- Howard County General Hospital, Inc.
- Liberty Medical Center, Inc.
- Maryland General Hospital
- Maryland Healthcare Education Institute
- Maryland Psychiatric Society, Inc.
- Maryland Radiological Society
- Maryland State Black Psychiatrists's Association
- Medical Mutual Liability Insurance Society of Maryland
- Memorial Hospital and Medical Center of Cumberland, Inc.

- Memorial Hospital
- Mercy Medical Center
- Montgomery County Department of Addiction, Victim & Mental Health Services
- Montgomery General Hospital
- Monumental City Medical Society
- Office of Occupational Health Services
- The Neurology Center, P.A.
- North Arundel Hospital
- Northwest Hospital Center
- Peninsula Regional Medical Center
- Prince George's County Medical Society
- Prince George's Hospital Center
- Sacred Heart Hospital
- St. Agnes Hospital of the City of Baltimore, Inc.
- St. Joseph Hospital
- Shady Grove Adventist Hospital
- Sinai Hospital
- Southern Maryland Hospital Center
- Spring Grove Hospital Center
- Springfield Hospital Center
- Suburban Hospital
- Taylor Manor Hospital
- Union Memorial Hospital
- University Health Center, University of Maryland
- Veterans Affairs Medical Center
- Washington Adventist Hospital
- Washington County Hospital

Committee members

- Chairperson William L. Thomas, M.D.*
- Vice-Chairperson Abdul Nayeem, M.D.*
- Carlos A. Alarcon, M.D.*
- Timothy D. Baker, M.D.*
- James Castellano, M.D.*
- Irvin H. Cohen, M.D.*
- Worth B. Daniels, M.D.*
- Susan Ferrand, M.D.*
- J. B. Fitzgerald, M.D.*
- Carol J. Johns, M.D.*
- Deusedit Jolbitado, M.D.*
- Henry H. Kwah, M.D.*
- Sidney B. Seidman, M.D.*
- Carl Soderstrom, M.D.*
- David Solomon, M.D.*
- Bernard Tabatznik, M.D.*

Advisory member

- Jack L. Mason, Ph.D.*



Committee on Drugs

Mr. President and Members of the House of Delegates:

The Med Chi bylaws state that the Committee on Drugs shall be "responsible for evaluating the appropriateness of prescribing controlled dangerous drugs and shall work closely with appropriate governmental authorities in controlling the abuse of controlled dangerous substances by physicians."

The committee has a specific, statutorily-mandated role in the process by which physicians receive approval for the use of amphetamines and methamphetamine. State regulations require that physicians must request approval from the medical consultant to the Division of Drug Control for the prescribing of amphetamine. To prescribe methamphetamine, the physician must receive *prior* approval from the medical consultant. The secretary of Health and Mental Hygiene appoints the medical consultant. In 1993, as in past years, the secretary appointed the chairperson of the Committee on Drugs as medical consultant.

The regulations further provide that if there is any doubt as to the validity of the diagnosis of a condition justifying the use of amphetamines, the documentation shall be submitted to the Committee on Drugs by the medical consultant for that committee's review and advice. The Committee on Drugs reminds all physicians in Maryland of their responsibility to request approval for the use of amphetamines from

the medical consultant. Requests should be addressed to the chairperson of the Committee on Drugs at the Med Chi offices.

The committee continues to strive to maintain a balance between educating physicians about their prescribing practices and supporting discipline for those who abuse these privileges. The chairperson appreciates the continued dedication and commitment of members and staff to the education of physicians in this important aspect of their practice.

Committee members

Chairperson Ramesh K. Khurana, M.D.

Harbhajan S. Ajrawat, M.D.

George H.A. Bone, M.D.

Milton H. Buschman, M.D.

Stanley Z. Felsenberg, M.D.

Stephen A. Hirsch, M.D.

Dante U. Monakil, M.D.

Beatrice L. Selvin, M.D.

Patrick J. Sheehan, M.D.

John R. Smith, M.D.

Albert H. Taub, M.D.

Donald B. Vogel, M.D.

□ □ □

Editorial Board of the *Maryland Medical Journal*

Mr. President and Members of the House of Delegates:

This report covers the calendar year 1993 (Volume 42) and the first four months of 1994. Throughout this period, the Editorial Board of the *Maryland Medical Journal* encouraged the submission of original research, case studies, review articles, medical history, and diagnostic and therapeutic updates, as well as commentaries and letters to the editor on all subjects of interest to Maryland physicians.

The April 1993 issue featured the 1993-1994 Med Chi president, Joseph Snyder, M.D.; the September 1993 issue contained the annual committee reports; and the December

1993 issue included the 1994 legislative directory. The March 1993 issue was dedicated to performing arts medicine. In the May 1993 issue, several articles covered the hundredth anniversary of The Johns Hopkins University School of Medicine. Donald "Ted" Lewers, M.D., who was elected to the AMA board of trustees, was featured in the July 1993 issue. The theme of the August 1993 issue was public health in Baltimore City. Special issues in 1994 have included alcohol and other drug abuse (January), long-term care (February), Church Home and Hospital (March), and child abuse (April).

Debra Wertheimer, M.D., and Diane L. McNally, B.S.Pharm., received the best article award for 1992 for "Strategies to Reduce the High Cost in Patient Noncompliance," which was published in the March issue of that year.

The editorial board is grateful to the following specialists who contributed their time and expertise in reviewing manuscripts:

- ✦ Steven J. Brand, M.D., F.A.C.S.
- ✦ Louis C. Breschi, M.D.
- ✦ Diane M. Dwyer, M.D.
- ✦ Jack Flowers, M.D.
- ✦ Stephen S. Gottlieb, M.D.
- ✦ Tah-Hsiung, M.D.
- ✦ R. J. O'Connell, M.D.
- ✦ Margaret B. Rennels, M.D.
- ✦ Daniel G. Sapir, M.D.
- ✦ Edward Sellers, M.D., Ph.D., F.R.C.P.C.
- ✦ John E. Smialek, M.D.
- ✦ Patrick Walsh, M.D.
- ✦ Andrew Whelton, M.D., F.A.C.P., F.C.P.

The editorial board of the *Maryland Medical Journal* encourages Med Chi members to communicate regularly and often about any and all facets of the publication. Article submissions, letters to the editor, suggestions, and constructive comments are always welcome.

Committee members

Editor Victor R. Hrehorovich, M.D.
 Associate editor Henry P. Laughlin, M.D., Sc.D.,
 Sc.S.D., Litt.D.
 Timothy D. Baker, M.D.
 John W. Buckley, M.D.
 Bayani B. Elma, M.D.
 Kevin Scott Ferentz, M.D.
 Nelson G. Goodman, M.D.

Barton J. Gershen, M.D.
 Robert G. Knodell, M.D.
 Herbert L. Muncie, M.D.
 Chris Papadopoulos, M.D.
 Marilyn S. Radke, M.D., M.P.H.
 Eric S. Wargotz, M.D.

Advisory member

Carmine M. Valente, Ph.D.



DIANE L. McNally, B.S. PHARM, ACCEPTS THE AWARD FOR 1992 *MARYLAND MEDICAL JOURNAL* BEST ARTICLE AT THE SEMIANNUAL MEETING. Ms. McNally was coauthor with Debra Wertheimer, M.D., of "Strategies to Reduce the High Cost of Patient Noncompliance."

Committee on Emergency Medical Services

Mr. President and Members of the House of Delegates:

The Committee on Emergency Medical Services discussed a number of issues that had a direct impact on the delivery of emergency services in Maryland. Many issues are ongoing and will require further discussion and monitoring in the coming year. Highlights of important issues discussed include the following.

Emergency department observation units. At the beginning of the year, the committee invited a staff consultant to the Board of Physician Quality Assurance (BPQA) to address the committee about emergency department (ED) observation units. The BPQA expressed an interest in addressing ED problems and raised the issue of ED obser-

vation units. The committee reviewed the use of these units in other states, the fact that a RBRVS code had been assigned to the ED observation unit for billing purposes, and Maryland's waived status in comparison with other nonwaivered states. It was the belief of the committee that health system reform would spark the resurgence of ED observation units in Maryland, and the hospitals would initiate them as required. If the units are established, BPQA maintains that there should be a clear understanding of who is in charge, a definitive chain of command, a clear demarcation of when a patient is transferred from one physician to another, and good documentation. The committee will revisit this issue when it becomes applicable to Maryland.

Emergency department overcrowding. A review of data from the American Hospital Association showed that ED patient visits had increased by 8.7% in the first quarter of 1993 as compared to the same period in 1992. Committee members noted, however, that the increase in primary care physicians' involvement in directing their patients to use EDs appropriately has resulted in a reduction in ED visits in some geographical areas. Because overcrowding leads to longer waiting periods, delayed admissions, etc., the committee will carefully monitor this issue in the coming year.

Dedicated issue of the Maryland Medical Journal. The committee spent several meetings discussing preparations for a dedicated issue of the *Maryland Medical Journal* (MMJ) on emergency medicine in Maryland after the MMJ's editorial board approved such an issue. Various committee members volunteered to gather data and write articles, including an update on emergency medicine in Maryland, emergency department overcrowding, emergency departments' alert status, and aero-medical information. Furthermore, the committee provided the editorial board with questions to ask John Ashworth, director, Shock Trauma, and Donald L. DeVries, Jr., Esq., chairperson, Emergency Medical Services Board, for interview articles for the dedicated issue. The dedicated issue is currently planned for November 1994.

Family violence. During the last year, the committee took an active interest in Med Chi's family violence initiative, the Maryland Physicians' Campaign Against Family Violence. A representative of the initiative was invited to address the committee to discuss various aspects of the endeavor and how it will assist emergency departments in their efforts to effectively diagnose and treat victims of family violence. The presentation highlighted the training aspect of the initiative, which will be provided in every hospital in Maryland, and the cooperation of the Maryland Hospital Association in getting this training into the hospitals.

Nursing home transfer form. Committee members reviewed the current nursing home transfer form and made suggestions about revising it to include pertinent information on living wills and resuscitation status. The committee will continue its work on this matter in the coming year.

Legislative endeavors. The committee actively reviewed and discussed various legislative matters pending before the Maryland legislature that pertained to emergency medicine. Of particular interest was the cap on non-economic damages. Committee members were encouraged to support the cap by contacting their legislators and making them aware of its importance in controlling health care costs and containing the cost of malpractice insurance premiums.

Members of the committee attended Med Chi's Legislative Committee meetings, participated in Doctors' Day in Annapolis, and testified before the state legislature on matters pertaining to emergency medicine.

Emergency Medical Services Advisory Council. This year the committee's chairperson was appointed to the EMS Advisory Council and serves as the chairperson of the council's finance committee. The committee was asked to bring its concerns and issues to the chairperson so that he may take them to the advisory council for discussion. Since the advisory council was still in its formation stages, the chairperson expects the coming year to be the beginning year for addressing critical issues.

Committee members

Chairperson Murray A. Kalish, M.D.
 Suril Ahuja, M.D.
 Barbara Bach, M.D.
 Anne Salmon Barone, M.D.
 Randy Sue Ellis, M.D.
 Peter M. Fahrney, M.D.
 Jeffrey L. Fillmore, M.D.
 Douglas Floccare, M.D., M.P.H.
 Jeannie L. Saunders, M.D.
 Michael A. Stang, M.D.

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Expansion of Health Care and Insurance Reform Technical Advisory Committee

Mr. President and Members of the House of Delegates:

The Expansion of Health Care and Insurance Reform Technical Advisory Committee (TAC) was one of four such committees established this year by Med Chi to address the various provisions of HB 1359. This TAC will work with the committee established by the Health Care Access and Cost Commission (HCACC) to study the potential for expanding the health insurance reforms embodied in HB 1359 into all areas of health insurance, including self-insurance plans, ERISA plans, and plans sold to employers with more than 50 employees. The TAC met twice during the year. The TAC is currently waiting for the HCACC to name its committee on expansion of health care and insurance reform and for this committee to establish an agenda so that the Med Chi TAC can begin its work with this committee.

Committee members

Chairperson Christian Jensen, M.D.

Timothy Baker, M.D.

Theodore E. Harrison, M.D.

Olisegum O. Lawoyin, M.D.

Susan Owens, M.D.

Patricia A. Savadel, M.D.

Howard L. Siegel, M.D.

Henry N. Wagner, M.D.

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Family Violence Task Force

Mr. President and Members of the House of Delegates:

This was the start-up year for the Family Violence Task Force. This multidisciplinary task force is composed of representatives from Med Chi, Maryland Alliance Against Family Violence, Maryland Hospital Association, University of Maryland's department of family practice, Maryland Nurses Association, House of Ruth, Maryland Network Against Domestic Violence, Maryland Emergency Room Nurses Association, Maryland Chapter of the National Association of Social Workers, Maryland Chapter of the Society for Hospital Social Work Directors, Maryland Chapter of the American College of Emergency Physicians, Maryland Academy of Family Physicians, Maryland Society of Internal Medicine, Department of Health and Mental Hygiene, Department of Human Resources, Obstetrical and Gynecological Society of Maryland, Maryland Chapter of the American Academy of Pediatrics, and Med Chi's Alliance.

The charge to the task force was to design an educational program to train physicians about the prevalence of family violence, its impact on the health and well-being of victims, and the necessity of intervention by the medical community. Furthermore, the task force was charged with coordinating training efforts on family violence and coordinating family violence initiatives. The task force also was directed to review Maryland statutes and regulations and investigate the need to revise or promulgate legislation concerning family violence.

The task force initiated the Maryland Physicians' Campaign Against Family Violence and chose the theme, "Unlock the Silence. Trust is the Key." This theme was chosen because often the most difficult thing victims and health providers have to do is break the silence surrounding abuse situations. Trust is the key because patients trust physicians and other health care providers to

keep matters confidential and to look after their best interests.

After choosing the theme, the task force chose the logo of a lock and key for the campaign and determined the design and colors to be associated with the campaign. After these initial determinations and funding from Med Chi, the Department of Human Resources, the Department of Health and Mental Hygiene, and a federal grant, the task force designed educational materials and a training format based on these materials. The task force decided to address family violence in a three-part initiative, with the first initiative focused on domestic violence.

The task force met for nine working sessions, and subcommittees held numerous meetings beyond the nine working sessions to produce materials related to domestic violence. These efforts resulted in the task force producing a 42-page manual on domestic violence that was approved for 2 CME credits in Category 1 of the Physician's Recognition Award of the American Medical Association. The task force also produced a tent card for display in offices and clinic areas and a victim's question card. These items were included with the physician's manual. Approximately 7,000 of these manuals were sent to Med Chi members free of charge. The manuals contain facts about domestic violence, myths about domestic violence, the definition of domestic violence, barriers to identification, issues surrounding interviewing the patient and clinical diagnosis and findings, intervention, hints about documentation, legal considerations, and domestic violence resources. The manual was based on information produced by the American Medical Association and the Ohio Medical Association

with additions suggested by the task force and additions pertinent to Maryland. A victim's brochure was also developed and is being circulated to Maryland hospitals and other facilities. The victim's brochure is in the process of being translated into Korean and Spanish and another brochure is being produced for the African-American community. A public health nurses' training packet on domestic violence is also being finalized.

The task force contracted with Carol J. Scott, M.D., Medical Education Group, Inc., to develop a learning retreat for trainers who would be presenting a seminar, based on the domestic violence manual, to hospitals across the state. Materials produced in association with this endeavor were a facilitator's manual and slides, as well as evaluation forms, attendance sheets, pre-seminar assessments, seminar outlines, and seminar announcements. As a result of this initiative, two learning retreats were presented on May 20 and 21 at Med Chi. Each session lasted from 9:30 a.m. to 4:00 p.m. Eighty-nine physicians, nurses, and domestic violence advocates from across the state were trained. With the cooperation and coordination of the Maryland Hospital Association, contact people were identified at each hospital in Maryland and coordination of seminar presentations has begun. These seminars have been approved for CME credit for physicians and nurses. To date, three hospital trainings have occurred and five more were scheduled for August along with one HMO training. Scheduling for other hospitals, HMOs, and component societies is continuing across the state.

Although most of the task force's activities have centered around education, the task force undertook other responsi-



MATERIALS DEVELOPED FOR THE MARYLAND PHYSICIANS' CAMPAIGN AGAINST FAMILY VIOLENCE.

bilities during the last year. As a result of task force deliberations, the October 1993 issue of the *Maryland Medical Journal* (MMJ) contained an article on Med Chi's family violence campaign and a letter by Med Chi president Joseph Snyder, M.D., encouraging physicians to take a leadership role in alleviating and eradicating family violence. The cover of the MMJ focused on family violence and carried the campaign's theme. Further task force deliberations resulted in an issue of the MMJ (April 1994) dedicated to child abuse to coincide with National Child Abuse Prevention month. The lead article was written by Maryland Congresswoman Constance Morella. The issue has been sent to key state legislators, federal legislators, public health officials, and other interested parties who have requested it.

The task force also reviewed the Domestic Violence Bill of 1994 and the Domestic Violence Response Act, which set up model sites for domestic violence training programs and advocacy in three hospitals in the state. The task force supported both bills; task force members testified on both and worked with legislators who were sponsoring them. Both bills were signed into law.

In the coming year, the task force will focus on continuing its educational efforts on domestic violence and moving into the next phase of its three-part initiative—child abuse.

The task force would like to thank Joseph Snyder, M.D., for being the motivating force behind the family violence initiative and would also like to thank the communications department of Med Chi, the CME department of Med Chi, and the chief operating officer's secretarial staff for their diligent efforts in making the physicians' campaign an outstanding Med Chi enterprise.

Committee members

Co-chairperson Martin P. Wasserman, M.D.
Co-chairperson Hiroshi Nakazawa, M.D.
Louise Andrew, M.D., Maryland Chapter,
American College of Emergency Physicians
Moya Atkinson, Maryland Chapter,
National Association of Social Workers
Lillian R. Blackmon, M.D., Maryland Chapter,
American Academy of Pediatrics
Jacquelyn Campbell, R.N., Ph.D., Johns Hopkins
School of Nursing
The Honorable Caroloyne Colvin, Secretary,
Maryland Department of Human Resources
Rita Costello, Maryland BlueCross BlueShield
Harrold T. Elberfeld, M.D., OB-GYN Society of
Maryland
Patricia Epifanio, R.N., M.S., CEN, Maryland
Emergency Room Nurses Association

Jann Jackson, M.S., House of Ruth
J. Leonard Lichtenfeld, M.D., Maryland
Society of Internal Medicine
Fred Magaziner, D.D.S.
Roseanne M. Matricciani, R.N., J.D.,
Chief Operating Officer, Med Chi
Nancy McCaslin, R.N., Maryland Nurses
Association
John Meyerhoff, M.D., Parents Anonymous
Beverly Miller, Vice President, Maryland
Hospital Association
Herbert L. Muncie, M.D., Chairperson, Univer-
sity of Maryland Department of Family
Medicine
Abdul Nayeem, M.D., Maryland Academy of
Family Physicians
Jeanette Nazarian, Med Chi Medical Student
Association
Sallie Rixey, M.D.
J. Courtland Robinson, M.D., M.P.H.
M. Virginia Ruth, Ph.D., R.N., Maryland Nurses
Association
Madrian Snyder, Med Chi Alliance
Kinaya C. Sokoya, M.B.P.A., Maryland Net-
work Against Domestic Violence
Joan Stine, Department of Health and Mental
Hygiene
Stephen P. Teret, J.D., M.P.H., Johns Hopkins
Injury Prevention Center
Dorothy Thormaehlen, Sexual Assault/Domes-
tic Violence Center
Laura Saltzman Trazzi, L.C.S.W.-C., Maryland
Chapter, Society of Hospital Social Work
Directors
Joanne Tulonen, M.P.A., Maryland Alliance
Against Family Violence
Betsy Zaborowski, Psy.D., Metropolitan Psy-
chological Associates

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Finance Committee

Mr. President and Members of the House of Delegates:

The Finance Committee met seven times during the 1993-1994 year to discuss important financial matters. Currently, the 1993 financial records are being audited. We will publish the complete audit report, supplemental schedules, and footnotes when the audit has been completed.

The committee drafted a 1994 budget that subsequently was revised to reflect estimated income and expenditures more accurately. This budget received the proper approval of the Executive Committee and Council and is presented in the Supplementary Reports section of this journal.

During the 1993-1994 year, budgeted approved capital expenditures were made for a new telephone system with enhanced features that allow access to eight topics of current interest. These topics are available to any member or caller from every touchtone telephone. Approval also was granted to purchase new accounting and membership software, as well as computers. Capital expenditures of this type will serve Med Chi for many years and allow us to operate more efficiently to meet the demands of our membership.



JOSEPH SNYDER, M.D., PRESENTS
SENATOR BARBARA MIKULSKI WITH SOME
GIFTS DURING HER VISIT TO MED CHI ON
APRIL 4, 1994.

A review of banking expenses led the committee to direct the chief operating officer and the controller to investigate proposals to service Med Chi's banking accounts. After careful consideration of all proposals, the committee recommended switching Med Chi's accounts to the First National Bank. This move resulted in actual savings to the Faculty and an expansion in services provided.

An internal analysis of payroll processing by administrative staff resulted in switching payroll processing for Med Chi employees from Ceridian to the ADP system. The committee reviewed the issue and noted the advantages in making this change.

New IRS requirements concerning the non-deductibility of lobbying expenses required that Med Chi notify every member of that portion of their dues that could not be deducted because it was attributable to Med Chi's lobbying expenses. The committee reviewed all correspondence related to notification to membership and directed staff to emphasize the importance of lobbying in the mailing to the membership.

Questions to the committee concerning reimbursement for expenses led the committee to adopt a "white paper" drafted by the chairperson. This paper was presented to and approved by Council.

The committee also began to work on maximizing Med Chi's investments and reviewing Med Chi's investment portfolio. A subcommittee was assigned to examine current policy, make recommendations, and report back to the entire committee.

We are also pleased to report that our peer review and physician rehabilitation programs were extensively audited by the state legislative auditors. This was a special performance audit that covered a three-year period from August 1, 1990, to July 31, 1993. No material deficiencies were found and in several areas the auditors commended our efforts.

Committee members

Chairperson Paul A. Stagg, M.D.
Sheldon B. Bearman, M.D.
Michael A. Dobridge, M.D.
Carol W. Garvey, M.D.
Allan D. Jensen, M.D.
Reynaldo L. Lee-Llacer, M.D.
J. David Nagel, M.D.

Finney Fund Committee

Mr. President and Members of the House of Delegates:

As required by its bylaws, the Finney Fund Committee met with the Library and History Committee to provide input on acquisitions in the area of surgery. Fund members made their recommendations based on the Brandon Hill List of titles. The total amount expended from the Finney fund for books and journals in the area of surgery was \$11,935.00

Committee members

*Chairperson Joseph H. Hooper, M.D.
Edmund C. Beacham, M.D.
John W. Buckley, M.D.
Robert G. Greenfield, M.D.
Susan R. Guarnieri, M.D.
Theodore E. Woodward, M.D.*

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Committee on Focused Professional Education

Mr. President and Members of the House of Delegates:

The Committee on Focused Professional Education offers evaluation for education to physicians with perceived deficits in their practices. Each evaluation results in a report that defines deficits and recommends educational measures that will enable the physician to improve his or her care of patients.

The committee receives referrals from Maryland hospitals and from individual physicians. Referrals from the Board of Physician Quality Assurance result from findings of peer review investigations. Referrals have also come from hospitals and licensing agencies in surrounding states.

The committee received 15 referrals for evaluation in the past year. The recommendations resulting from those evaluations included education in medical record keeping, measures to end isolation in practice, directed continuing medical education activity, medical school courses and residencies, and attendance at grand rounds.

Committee members

*Chairperson Edward J. Kowalewski, M.D.
Pablo E. Dibos, M.D.
Kevin S. Ferentz, M.D.
Michael J. Richardson, M.D.*

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Paul Markowski, of the AMA, and Joseph Snyder, M.D., stand next to a poster that displays a letter to federal representatives outlining the principles that physician organizations agree must be contained in health system reform legislation. The poster also lists the state medical societies and the 64 medical specialty societies that support these principles.

HMO Quality and Practice Parameters Technical Advisory Committee

Mr. President and Members of the House of Delegates:

The work of the HMO Quality and Practice Parameters Technical Advisory Committee (TAC) has been divided into two areas: review of the *Health Plan Employer Data and Information Set and Users Manual Version 2.0* (HEDIS 2.0) and development of strategies for implementing practice parameters. The first issue has taken most of the committee's time to date.

After carefully reviewing the quality measures and specifications outlined in HEDIS 2.0, the committee forwarded its comments to Joseph Mead, M.D., chairperson of the State Work Group on HMO Quality and Practice Parameters, through J. Ramsay Farah, M.D., chairperson of the Med Chi TAC and member of the work group. The comments focused on physician satisfaction, adult immunizations, childhood immunizations, and mammography screening. Our recommendations were adopted in the document.

The review of the HEDIS document was time well spent since the developer of HEDIS, the National Committee for Quality Assurance, has been chosen by the Health Care Access and Cost Commission as the contractor for Maryland's HMO performance measurement pilot project.

Dr. Farah and committee staff kept members informed about the presentations made to the state work group on

practice parameters. The committee supported Dr. Farah's efforts to have the work group endorse an affirmative defense demonstration project similar to the Maine Medical Liability Demonstration Project.

If this demonstration project goes forward as planned, Med Chi's input through the TAC and specialty societies will be crucial. It is clear that the TAC will continue to be active over the next year.

Committee members

Chairperson J. Ramsay Farah, M.D.

John A. Bartkovich, M.D.

David S. Davis, M.D.

L. Thomas Divilio, M.D.

Sheldon Goldgeier, M.D.

J. Leonard Lichtenfeld, M.D.

Christine A. Marino, M.D.

Ibrahim A. Razzak, M.D.

Robert Ruderman, M.D.

Mark S. Seigel, M.D.

John C. Seymour, M.D.

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Committee on Hospital Medical Staffs

Mr. President and Members of the House of Delegates:

The Committee on Hospital Medical Staffs met on three occasions during the past year and discussed several issues of significant importance to hospital-based physicians in Maryland, in spite of a continuing problem of inadequate attendance. The committee discussed and approved the concept of a "fax tree" that would connect Med Chi with key hospital staff members across the state, providing immediate information access to some areas of Maryland that otherwise would not easily be reached. Particularly in rural areas, the hospital forms a center for all local and regional

medical activity and is the obvious place of contact from Med Chi to the local physician community.

The committee further addressed a matter of serious concern to Maryland physicians and issued a proposed resolution that has been submitted to the American Medical Association's board of trustees for review and action. Specifically, the committee reviewed a plan adopted by a health maintenance organization providing services in Maryland that designates attending physicians for its patient enrollers in two specific hospitals in the Baltimore City area. The

committee felt strongly that this experiment would endanger the relationship of patients to their private treating physicians and that any attempt by an insurer to interfere with the physician-patient relationship in this manner should be strongly discouraged. The resolution submitted to the AMA ultimately resolved "that the American Medical Association, in concert with the JCAHO, take all possible steps to ensure that personal physicians maintain direct responsibility to direct/monitor each patient hospitalization from admission to discharge." This resolution was also supported at the AMA by the Georgia delegation and its reception by the reference committee to which it was referred was favorable, although the resolution was submitted to the board of trustees for further report.

Committee members

Chairperson Ralph E. Longway, M.D.
C. Alex Alexander, M.D.
Charles J. Arnold, M.D.
Herman Brecher, M.D.
Edward A. Carter, M.D.
Michael E. Crouch, M.D.

Alan Davis, M.D.
Randy F. Davis, M.D.
Benjamin V. Del Carmen, M.D.
Andrew Fridberg, M.D.
Henry Farkas, M.D.
L. Myrton Gaines, Jr., M.D.
Arthur L. Gudwin, M.D.
Davis M. Hahn, M.D.
Brian M. Hepburn, M.D.
Claudius Klimt, M.D.
James R. Kunec, M.D.
Michael LaPenta, M.D.
Francis C. Mayle, Jr., M.D.
Ata Moshvedi, M.D.
Parviz Navidi, M.D.
William Prescott, M.D.
Garry R. Ruben, M.D.
Carl Schoenberger, M.D.
Edward L. Sherrer, M.D.
John B. Umhau, M.D.

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Immunizations and Infectious Diseases Subcommittee

Mr. President and Members of the House of Delegates:

This year the Immunizations and Infectious Diseases Subcommittee has continued its work in considering and advising on all phases of health maintenance, preventive maintenance, and public health.

The AMA requested that all state medical societies "explore with their state health departments the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids." The committee found that such establishments are not now regulated in Maryland. However, a bill introduced this year (§601-06, General Recommendations for Control of Communicable Diseases) about sterilization of instruments or equipment, addresses electrologists, nurses, physician assistants, and physicians. If the bill becomes law, regulations for tattoo businesses can be attached to it.

The committee considered and made recommendations to DHMH (Department of Health & Mental Hygiene) about the "free immunization" program under which physicians can be supplied vaccines at no charge. The Maryland program is in effect now, and the federal program will be

initiated October 1, 1994. An administration fee can be charged to the patient.

The committee considered and prepared testimony against the proposed COMAR 10.52.09 requirement for a unique, 14-digit identifying number for patients tested for HIV infection or CD4+ lymphocyte count on the basis that it would be unwieldy in a physician's office and that the substitution of "9" for unknown numbers would compromise the accuracy of the number.

Continuing its efforts to keep physicians and their office staffs apprised of the latest information about OSHA (Occupational Safety and Health Administration) regulations, the committee has had updates included in the "Chief Executive Officer's Newsletter" in the *Maryland Medical Journal*. In this regard, several new issues related to tuberculosis have become important as the incidence of the disease has increased, as health professionals have become more aware of the problems of identifying TB in AIDS patients, and as new, drug-resistant strains are being identified. On January 8, 1994, new MOSH regulations became effective regarding acceptable respirators (hepafilter masks). The committee

discussed the new DHMH treatment guidelines and recommended the development of a "branching tree" treatment chart, which would simplify presentation of treatment recommendations, depending on the physical findings in a patient. The committee presented a CME program at the 1994 annual meeting to address these issues and to make physicians aware of the Directly Observed Treatment (DOT) program in Maryland, through which outreach workers administer medications to patients with tuberculosis in their homes. The program is proving to be extremely effective in Maryland, as it has been in other states. In the summer of 1994, the committee is sponsoring staff seminars for those in physicians' offices who are going to prepare office exposure plans and train office personnel on the OSHA regulations and the new requirements regarding tuberculosis.

The committee discussed and made recommendations about the proposed "Recommended Schedule for Childhood Immunization in Maryland" to be released by DHMH. The new schedule should have the effect of speeding up the administration of immunizations in infancy and increasing the percentage of children who receive full protection.

Committee members

Chairperson Robert J. Ancona, M.D.
Timothy F. Doran, M.D.
Donald W. Wiczer, M.D.
Robert E. Yim, M.D.

Advisory members

Diane Dwyer, M.D.
Rose M. Matricciani, R.N., J.D.
Margaret Rennels, M.D.

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Legislative Committee

Mr. President and Members of the House of Delegates:

The 1994 session of the Maryland General Assembly concluded at midnight on Monday, April 11th. It was an active year for Med Chi with the Legislative Committee reviewing over 263 bills and taking positions on 155 bills before the various standing committees of the Maryland General Assembly. Additionally, issues arose every day in the form of amendments to legislation that had a direct or indirect impact on organized medicine. Overall, the year was a success with passage of the wrongful death cap bill; defeat of the Maryland Hospital Association-initiated ambulatory surgery licensing/uniform pricing and 10% tax bill; and the consideration given to the Health Care Patient Access Act.

There are two principal reasons for Med Chi's success in the 1994 legislative session. First and foremost was the structuring of regular meetings with other health care provider lobbyists as well as with Med Chi's component societies. These meetings, which began in the fall of 1993 and continued on a regular basis through the entire session, had the effect of organizing the health provider community and the Med Chi component societies into a group that knew the various issues and could respond quickly and effectively when asked. This coalition building proved to be particularly beneficial as new issues arose that could be quickly dissected, attacked, or supported as the case warranted.

Second, since the legislative efforts were more focused because of this regular meeting format, Med Chi's tremendous resources—particularly its member physicians—could be activated on specific issues in providing information to the Med Chi lobbyists or by themselves making expert presentations to various legislative committees.

Our efforts in the future will further refine the use of collaborative and inclusive decision-making patterns involving the health provider community and the Med Chi component and specialty societies.

With respect to the major issues that were resolved:

Wrongful death cap. The final, passed version was an amended form of SB 283. It provides for a new "cap" in the amount of \$500,000 that will apply to all cases (personal injury and wrongful death) arising after October 1, 1994. The cap is not retroactive. In addition, in a wrongful death case in which there are two or more survivors, the cap will be 150% of the cap amount (i.e., \$750,000). Beginning on January 1, 1996, and each January 1 thereafter, the cap amount will increase by \$15,000 (3% or less each year).

The cap bill finally passed with approximately two hours to go in the legislative session. Although it was not the final product that medicine would have liked, primarily because of the lack of retroactivity, it was a solution which medicine needed. There will be a number of wrongful death cases (the

best estimate is 250) that will remain "uncapped" by virtue of the *Streidel* court decision in March 1993. There is likely to be a substantial increase in malpractice premiums as a result of SB 283, although approximately half the increase will be due to the "uncapped" cases, which will gradually disappear from the system as they are settled or tried. Thus, despite a "sticker shock" from malpractice premium increases either later this year or early in 1995, about half the increase will gradually disappear and premiums will return to more moderate levels.

Medical Mutual has stated that the principal tort reform feature that "worked" was the cap on non-economic damages. Because of our collective efforts in the just-concluded session, the cap will be reimposed in wrongful death cases in Maryland and for that all of medicine should be thankful. It is a long-term solution that was absolutely required.

Free-standing ambulatory care facilities. This proposal by the Maryland Hospital Association had the unfortunate effect of causing serious disagreement within medicine. The hospital association promoted two different legislative proposals. The first was to declare a moratorium on granting exemption letters for the construction of free-standing surgicenters or endoscopy suites. The moratorium

on bills (SB 746 and HB 1621) was filed as the Health Resources and Planning Commission had, itself, decided not to impose a moratorium administratively. SB 746 was killed by the Senate Finance Committee; HB 1621 was never voted on by the House Environmental Matters Committee and, hence, died.

The hospital association's proposal contained in SB 737 and HB 1336 was not decided until the final day of the session. These bills (1) licensed free-standing ambulatory care centers or endoscopy suites; (2) required such facilities to charge "uniform" prices to all payors without discounts; and (3) imposed a 10% tax on the bills from such free-standing centers to be paid to the state Medicaid fund. Med Chi objected to the bills in their original form, but proposed licensing as a solution. HB 1336 was so amended and passed the House of Delegates but died in the Senate. Rather than settle for a licensing statute, the Maryland Hospital Association pushed until the very last minutes of the session for the uniform price and tax mechanism. Ultimately, no bill passed, although it is clear that a licensing bill would have been acceptable to the legislature had the Maryland Hospital Association relented.

Med Chi initiated several meetings with the Maryland Hospital Association prior to the session with an eye toward resolving the differences over this issue. Unfortunately, the hospital association was not willing to moderate its proposals and the net effect was that nothing passed.

Health care patient access. SB 472 (HB 691) was the "most heavily lobbied bill" of the legislative session according to the *Washington Post*. The health provider community rallied behind the bill; almost everyone else in the state opposed it, including the Maryland Chamber of Commerce; the Maryland AFL-CIO; most of Maryland's major employers, including BG&E, the Marriott Corporation, and the insurance and HMO industries; and, most importantly, the secretary of health and mental hygiene; the president of the Senate; the speaker of the House of Delegates; the chairperson of the Health Care Access and Cost Commission; the *Baltimore Sun* in its editorial pages; the City of Baltimore; Anne Arundel County; and a host of others.

Notwithstanding the opposition, the bill received a favorable report in the Senate Finance Committee (9-2) over the vehement objections of the committee chairperson, Senator Thomas P. O'Reilly. Senator O'Reilly only brought up the bill for a vote when forced to do so by a petition from his committee. He then worked with the president of the Senate to delay consideration of the vote so that when the session adjourned, the bill had not come up for final passage, even though it had been given preliminary approval by the Senate. Meanwhile, the House of Delegates, impatient with the Senate, amended an unrelated bill on the last day of the



ALLAN JENSEN, M.D., 1993-1994
COUNCIL CHAIRPERSON, SPEAKS TO THE
HOUSE OF DELEGATES.

session and passed a proposal to require HMOs to disclose publicly their criteria for provider selection; to provide appeal rights to providers who could not get into a panel or who had been dismissed from a panel; and to provide for continuity of care for patients whose providers were taken off a panel. These amendments also provided that there would be a seven-person study commission (including a member of Med Chi on behalf of the providers) to report to the legislature by December 1994 concerning the issue of opening health networks. While this bill only passed the House of Delegates, it is safe to say that, in both the House of Delegates and in the Senate, there was strong sentiment demonstrated this year for bringing HMO practices on provider selection under control.

The consideration given the Health Care Patient Access Act was unexpected. Indeed, most "insiders" believed the hearings on the bills would be "perfunctory." Our success with the issue indicates, first, that it is a core issue in health care of great and wide popularity, not only with the provider community, but with patients; and second, that organized activity can be successful even against great odds.

Other issues of interest. Proposals to mandate triplicate prescription forms (HB 516, SB 563), serialized prescription forms (HB 1010), or color-coded prescription forms (HB 876) were defeated after hearings by their respective committees. However, a bill to allow physician assistants to prescribe drugs was given a favorable report by the House Environmental Matters Committee and a fight ensued on the floor of the House of Delegates. Med Chi had been the only group in opposition to the bill in its original form, but, as a result of amendments placed on the bill to allow physician assistants in any clinical setting (not just hospitals as originally drafted) to prescribe and to further loosen the restrictions on physician assistants, Med Chi was able to persuade other health providers to join the fray. The result was a Med Chi victory on the floor of the House of Delegates: the measure was defeated by a vote of 51-76.

A more tortured story related to SB 401. Originally drafted as a bill by the health department to recognize national standards for the purposes of accrediting medical laboratories, the bill was amended in the voting session of the Senate Finance Committee to provide that medical laboratories could not engage in various practices with physicians' offices (providing specimens, pick-up services, etc). This is part of an ongoing campaign by medical laboratories to drive patients directly to the laboratories and is a replay of the "diagnostic test" issue that arose last year in HB 1359. The "voting session" amendments, however, exempted hospitals, nursing homes, and HMOs. Med Chi attacked these exemptions on the floor of the Senate. On successive days, Med Chi was successful in stripping these

exemptions from the bill (first by a vote of 23-22; then, on reconsideration, by a vote of 24-23). When the bill reached the House of Delegates, Med Chi was successful in stripping these voting session amendments altogether. Although the medical laboratories attempted to rework the bill in a joint House/Senate conference committee, time ran out and the bill died.

Competing medical records bills (SB 492 and HB 716) were harmonized on the last day of the session and passed. In their final form, the bills were extremely favorable to physicians, allowing the following charges for copying medical records: \$15 preparation fee, 50 cents per page for copying, and actual costs for postage and handling.

House Bill 967 was passed, creating a State Board of Acupuncture. In its final form, the bill requires a person to be licensed by this new board to practice as an acupuncturist. However, it does not apply to the performance of acupuncture by licensed physicians who are separately regulated in this context by the Board of Physician Quality Assurance (BPQA). The Acupuncture Advisory Committee is eliminated with the passage of this statute.

Committee members

Chairperson Hilary T. O'Herlihy, M.D.

Vice-chairperson, William C. Bruther, M.D.

Vice-chairperson, Arnold G. Levy, M.D.

Allegany County Medical Society

Frederick Miltenberger, M.D.

Anne Arundel County Medical Society

Michael S. Epstein, M.D.

Baltimore City Medical Society

Joseph W. Zebley, M.D.

Baltimore County Medical Society

Mayer C. Liebman, M.D.

Robert M. Taylor, M.D., alternate

Alan T. Wright, M.D., alternate

Calvert County Medical Society

Michael J. Dodd, M.D.

Caroline County Medical Society

Christian E. Jensen, M.D.

Carroll County Medical Society

Michael K. McEvoy, M.D.

Cecil County Medical Society

Timothy O'Donnell, M.D.

Charles County Medical Society

Arturo M. Monteiro, M.D.

COMMITTEE REPORTS

Guillermo Sanchez, M.D., alternate
Charles H. Wathen, M.D., alternate

Dorchester County Medical Society
Paul A. Stagg, M.D.

Garrett County Medical Society
Herbert H. Leighton, M.D.

Harford County Medical Society
Henry H. Kwah, M.D.

Howard County Medical Society
Melvin S. Rapelyea, M.D.

Kent County Medical Society
John C. Seymour, M.D.

Montgomery County Medical Society
Mary Anne Duke, M.D.

Prince George's County Medical Society
Harvey Fernbach, M.D., alternate
Reynaldo Lee-Llacer, M.D.

Washington County Medical Society
Randy Sue Ellis, M.D.

Wicomico County Medical Society
Hilda I. Houlihan, M.D.
Richard H. Meeks, M.D., alternate

Maryland Asthma and Allergy Society
John R. Bacon, M.D., alternate
Sean R. O'Brien, M.D.

Maryland-DC Society of Anesthesiologists
Robert L. Lyles, Jr., M.D.

Maryland Society of Cardiology
Mark M. Applefeld, M.D.
Herman C. Maganzini, M.D., alternate

Maryland Dermatologic Society
Jeffery G. Middleton, M.D.

Maryland Chapter, American College of Emergency Physicians
David S. Davis, M.D.
Lawrence S. Linder, M.D., alternate

Maryland Society of Eye Physicians and Surgeons
Joseph W. Berkow, M.D.
Allan D. Jensen, M.D., alternate
Alan R. Malouf, M.D., alternate
Basil S. Morgan, M.D., alternate

Maryland Academy of Family Physicians
Joseph W. Zebley, III, M.D.

Maryland Society of Gastrointestinal Endoscopy
Richard B. Williams, M.D.

Maryland Society of Internal Medicine
Sheila A. Walker, M.D.

Maryland Neurosurgical Society
Ronald J. Cohen, M.D., alternate
Henry M. Shuey, M.D.

Maryland Society of Nuclear Medicine
David C. Moses, M.D.

Obstetrics and Gynecological Society of Maryland
Steven M. Berlin, M.D.

Maryland Society of Orthopaedic, Rehabilitation, and Occupational Medicine Specialists
Neil A. Green, M.D.
Martin Z. Kanner, M.D., alternate

Maryland Society of Otolaryngology-Head and Neck Surgery
Ira D. Papel, M.D.

Maryland Society of Pathologists
John G. Newby, M.D., alternate
Alberto C. Seiguer, M.D., alternate
Howard L. Siegel, M.D.

Maryland Chapter, American Academy of Pediatrics
Robert W. Bright, M.D.
Melvin Stern, M.D., alternate

Maryland Society of Physical Medicine and Rehabilitation
Martin Z. Kanner, M.D.

John Staige Davis Society of Plastic Surgeons of Maryland
George T. Grace, M.D.

National Capital Society of Plastic Surgeons
Mark E. Richards, M.D.

Maryland Psychiatric Society, Inc.
Thomas E. Allen, M.D.
Scott D. Hagaman, M.D., alternate
Mayer C. Liebman, M.D., alternate

Maryland Radiological Society
Edward W. Lampton, Jr., M.D.
James D. Winthrop, M.D., alternate

Maryland Thoracic Society

Steven Schonfeld, M.D.

Maryland Urological Society

Robert B. Goldstein, M.D.

Members-at-large

Joseph A. Adams, M.D.

Albert Blumberg, M.D.

Norman K. Bohrer, M.D.

M. Justine Clark, M.D.

Joseph S. Fastow, M.D.

Gerri L. Goodman, M.D.

Nelson G. Goodman, M.D.

Eric Hasemier, M.D.

Thomas E. Hunt, M.D.

Seth H. Lourie, M.D.

Lawrence D. Pinkner, M.D.

Gary L. Rosenberg, M.D.

Howard M. Silby, M.D.

Margaret T. Snow, M.D.

Alliance

Mrs. Joy Epstein

Mrs. Lea Prichep

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Library and History Committee

Mr. President and Members of the House of Delegates:

The Library and History Committee met four times during the 1993-1994 association year. Our activities focused on the areas of collection development, long-range planning, and the library budget.

Committee members surveyed the current core clinical collection in their subject areas to identify items that were out-of-date. Staff reviewed the committee's recommendations and either deaccessioned the items or, if they were felt to have historical value, added them to the history of medicine collection. The committee also made suggestions for new acquisitions based on the Brandon Hill list of recommended texts and monographs.

The committee worked with staff on a long-range planning and mission statement development process. Staff presented recommendations and strategies for committee review and input. The final product was a series of goals and objectives for the next year, including increased library use by members and nonmembers, better control over the historical collections, and a finalized collection development policy.

Finally, the committee approved the library budget as required by its charge. It also approved use of monies from the Ruhrah Fund to support a tobacco control clearinghouse in the library if Med Chi receives funding from the Robert Wood Johnson Foundation for a SmokeLess State project.

We had three resignations over the past year. Stanford Goldman, M.D., left Baltimore to accept the position of chairman of the department of radiology at the University of Texas School of Medicine in Houston. Michael L. Levin, M.D., was appointed chairperson of the Mayor's Advisory Committee on AIDS. His responsibilities made it difficult for him to continue on the Library and History Committee. Victor Albites, M.D., resigned for personal reasons. We would like to take this opportunity to thank all of them for their committed service as members of the committee and wish them well.

Committee members

Chairperson Ronald H. Fishbein, M.D.

Samuel J. Abrams, M.D.

John S. Dalton, II, M.D.

Milford M. Foxwell, M.D.

Nancy T. Nichols, M.D.

Henry B. Wilson, M.D.

Theodore E. Woodward, M.D.

Advisory members

Richard Flint, M.A.

Ann Steele, M.D.

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Committee on Long-Term Care and Geriatrics

Mr. President and Members of the House of Delegates:

The Committee on Long-Term Care and Geriatrics met three times during the annual 1993-1994 Med Chi year. An issue of the *Maryland Medical Journal* devoted to geriatric medicine was published during the year. The committee completed its survey of nursing home medical directors regarding medical quality assurance guidelines in long-term care institutions in Maryland. The draft guidelines were completed and a consensus conference will be held at the University of Maryland. Another round of guidelines will then be sent to physicians around the country. The completed guidelines should be ready in the near future.

During the annual meeting, the committee presented a program regarding the Health Care Decision Act in different settings. It looked at nursing homes, ICUs, and ambulatory care and focused on physicians' responsibility. Jack Schwartz, Esq., who drafted the legislation and is counsel in the Office of the Attorney General, was the primary speaker. The committee chairperson discussed ambulatory care.

The committee reviewed the draft report on "Breast Cancer and Prostatic Screening Initiatives for Nursing Home Residents." The committee felt that there was a need for radiologists to make rules and regulations about what

criteria a patient must meet to be able to have a mammogram. The committee noted that many nursing home patients would not be able to have mammograms and that they are normally provided with the type of care that would spot breast masses. The committee concluded that considerations for mammography should include:

- ♦ Is the patient medically stable?
- ♦ Is the patient in end-stage or terminal condition?
- ♦ If the patient is medically stable and not in a terminal or end-stage condition, is the patient able to cooperate with mammography?

Committee members

Chairperson George Taler, M.D.

Roland V. Goco, M.D.

Seymour Goldgraben, M.D.

Allan H. Macht, M.D.

Ruben Reider, M.D.

Paul S. Rhodes, M.D.

Gordon M. Smith, M.D.

Joseph W. Zebley, M.D.

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Committee on Managed Care and Third Party Liaison

Mr. President and Members of the House of Delegates:

The Committee on Managed Care and Third Party Liaison continued to address managed care issues during the 1993-1994 annual year and to be responsive to physicians across the state regarding their concerns about managed care issues.

An important issue addressed by the committee concerned the alleged laboratory overpayments by Pennsylvania Blue Shield (PBS) for organ panels. Physicians in Montgomery and Prince George's counties were informed by PBS that they were responsible for overpayments dating back more than two and a half years. The committee supported the position of the physicians in Montgomery and Prince George's counties that they were "without fault" and

encouraged staff to become actively involved in pursuing the issue. The committee also supported the resolution passed by the House of Delegates in September 1993 to oppose the action taken by PBS and to have Med Chi work toward a resolution of the matter. After attending a pre-hearing conference and a hearing on the matter with the American Medical Association and a representative from the Pennsylvania Medical Society, Med Chi received notification on July 20, 1994, that the Medicare hearing officer ruled in favor of the physicians. This ruling affected physicians in Washington, DC, Pennsylvania, New Jersey, Maryland, Virginia, and Delaware and was a true victory for organized medicine.

Another Medicare issue addressed by the committee concerned Medicare's denial of consultations billed by a provider who has seen the patient within the previous three years. The committee's concerns were verbalized to Barry Gold, M.D., medical director, Maryland Medicare, who brought the committee's concerns to the Health Care Financing Administration (HCFA). On June 28, 1993, it was announced that Medicare would no longer deny consultations billed by a provider solely because he/she has seen the patient within the previous three years. The committee believed that this reversal of policy was consistent with CPT guidelines.

The committee had received a number of inquiries concerning the use of RBRVS by M.D.IPA. Physicians presented information to the committee that indicated severe cuts in reimbursement when using this new payment method. The committee raised this issue with Eric R. Baugh, M.D., executive vice president of medical affairs, MAMSI, who investigated the matter and immediately resolved the problem by issuing correspondence to participating providers stating that the health plan "has decided at this time *not* to continue to utilize the RBRVS reimbursement methodology in calculating our fee maximums."

Another HMO issue that surfaced concerned the marketing of an indemnity product under the auspices of an HMO. Members expressed concern that the indemnity product was being administered by the HMO and not by a separate indemnity insurer. The matter was referred to Med Chi's legal counsel, who followed through with the insurance commissioner's office and was assured that the indemnity product would be administered separately from the HMO product.

Seeing the need to stay informed and abreast of managed care and insurance issues, the committee sponsored two events at Med Chi's Annual Meeting in Hagerstown. The first event was an AMA-sponsored managed care workshop; the second event was a presentation by the insurance commissioner. Both events were well received and the committee looks forward to sponsoring other managed care educational endeavors in the future.

A new program, instituted by HealthPlus, resulted in anxiety for many of our members. This new program required participating physicians to participate in a direct deposit checking program. By participating in this program, physicians would also have to authorize HealthPlus to make withdrawals any time a deposit was made inadvertently. After reviewing the matter, the committee felt that this requirement was greatly intrusive and a member of the committee was charged with addressing the issue with HealthPlus. HealthPlus readily acknowledged the concerns expressed by physicians and immediately rectified the issue.

The committee's Workers' Compensation survey identified the following as the **biggest** problems with Workers' Compensation:

- ♦ low payment schedule;
- ♦ dealing with bureaucracy and poor communication;
- ♦ claim disputes;
- ♦ delayed payment;
- ♦ insurance companies delaying decisions;
- ♦ excessive paperwork;
- ♦ policy of so many details; and
- ♦ inexperience/incompetence of claim specialists/representatives.

While the physicians did not identify any assets of Workers' Compensation from the physicians' perspective, they did identify the following assets for the patient:

- ♦ worker rights/protection for bona fide injuries;
- ♦ provide coverage for uninsured/low income workers to receive decent health care; and
- ♦ removes patient need for financial worry for medical bills.

In the managed care survey sponsored by the committee, physicians indicated that the most frequent complaints about managed care by their patients concerned the referral process, coverage limitations, a lack of local specialists, inconvenience for radiological services, and poor psychiatric coverage. For physicians, managed care systems had too much paperwork, low reimbursement for actual services provided, decreased quality of care, and infringement on the doctor-patient relationship.

Referral to the committee of physician complaints about CIGNA's pilot Admitting Officer Program at Saint Joseph's Hospital resulted in support for finalizing a resolution concerning the matter for forwarding to the AMA. It was the position of the committee that CIGNA's pilot program, in which two designated hospital physicians were directing and monitoring the patient's care from admission to discharge, disrupted the physician-patient relationship and raised a variety of liability issues. The CIGNA resolution was heard at the AMA and will be reported on at the interim meeting in Hawaii. The committee wishes to thank the members for their referrals and wishes to thank the medical director members and the managed care networks that assisted in resolving many of the issues before the committee.

Committee members

Chairperson Benjamin Avrunin, M.D.

Vice-chairperson Joseph W. Berkow, M.D.

Sunil K. Ahuja, M.D.

Eric R. Baugh, M.D.

Stanley Z. Felsenberg, M.D.
 Jay Gerstenblith, M.D.
 Howard Hoffberg, M.D.
 Perry Hookman, M.D.
 Arthur T. Keefe, Jr., M.D.
 Lewis Kellert, M.D.
 Robert W. Macht, M.D.
 Jose Martinez, M.D.
 David C. Moses, M.D.
 Susan Owens, M.D.
 Selvin Passen, M.D.
 Lawrence D. Pinkner, M.D.

Ruben Reider, M.D.
 Henry S. Sabatier, M.D.
 Patricia A. Savadel, M.D.
 Alan Z. Steinberg, M.D.
 Stephan L. Werner, M.D.

Advisory members

Barry Gold, M.D., BCBSM Medicare
 medical director
 Daniel McCrone, M.D. BCBSM senior vice
 president and corporate medical director

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Maternal Welfare Subcommittee

Mr. President and Members of the House of Delegates:

The Maternal Welfare Subcommittee continued to be very active during the 1993-1994 year. At the beginning of the year, the subcommittee received approval from the Executive Committee of its recommended protocol to hospitals for the management of the live abortus. A review of Maryland hospitals showed many of the hospitals in the state have been following some form of this recommended protocol.

The subcommittee's maternal mortality review got off to a good start with the presentation of maternal mortality cases by resident physicians. The residents prepared a summary of the case for presentation to the subcommittee and came prepared with a thorough knowledge of the case to answer specific questions posed by subcommittee members. To date, three cases have been confidentially reviewed under the auspices of medical review activities for the purpose of preparing educational articles in the *Maryland Medical Journal*. The quality of the presentations, as prepared by the residents, has been excellent and the subcommittee has felt that the experience has been mutually rewarding. It has been through the cooperation of Maryland's hospitals that these reviews have been possible and the subcommittee appreciates the efforts that the hospitals have made to advance this activity. The addition of an anesthesiologist with expertise in the delivery of anesthesia to pregnant women has added to the quality of the medical reviews and the subcommittee welcomed the addition of Cawas M. Antia, M.D., as a member. The chairperson and key contact person for this activity is Russell W. Moy, M.D.

In conjunction with the Subcommittee on Infant, Child and Adolescent Health, the subcommittee reviewed the

Healthy Start initiative concerning infant mortality reviews. This initiative will combine the expertise of these two subcommittees in reviewing infant deaths from 20 weeks' gestation (including miscarriages and stillbirths) to one year of age. The purpose of the review will be to provide suggestions for improving the delivery of services to women in the Healthy Start program.

As part of its ongoing educational activities, the subcommittee reviewed the federal activity related to the U.S. Public Health Service (PHS) recommendation on folic acid for women, the Maternal and Child Health Bureau's fact sheet on folic acid and neural tube defects, and the Food and Drug Administration's final rule on "Food Labeling: Health Claims and Label Statements; Folic Acid and Neural Tube Defects." The subcommittee plans to continue to monitor activities related to the issue of folic acid for women and will disseminate information as it receives updates on this subject.

Another important item on the subcommittee's agenda was a review of the *Journal of the American Medical Association* article, "The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City." The article examined the relationship between prenatal care and birth weight among a population of prenatal cocaine users. The results of the study indicated that prenatal care among cocaine users is associated with significant improvements in birth weight and that enrollment of cocaine users in prenatal care may be an effective start to a more comprehensive approach to this problem. The subcommittee found this article informative and has

filed it for referral, if indicated, during its Healthy Start initiative.

Concern for pregnant women at risk for contracting communicable diseases that could infect the baby before it is born led the subcommittee to review the Department of Health and Mental Hygiene's (DHMH) communicable diseases fact sheets and communicable diseases summary. These materials are being distributed to schools, health departments, and day care centers by DHMH and have been forwarded for publication to the *Maryland Medical Journal*.

Review of a NIAID (National Institute of Allergy and Infectious Disease) news release led the subcommittee to discuss the efficacy of treating all HIV positive mothers with AZT. The NIAID study indicated that a treatment regimen consisting of AZT given to the mother both antepartum and intrapartum, as well as to the newborn during the first six weeks of life, significantly reduced the risk of maternal-infant transmission of HIV for women with baseline CD4+ lymphocyte counts >200 cells/mm³. The subcommittee noted that some hospitals have adopted the results of this study and have implemented AZT treatment, while other hospitals are awaiting further information before instituting

a new policy. Since this information was relatively new and the study limited, the subcommittee decided to monitor further activities and information concerning this treatment before recommending dissemination to the entire membership.

The subcommittee appreciates the input from Med Chi members and looks forward to another year of addressing issues of concern and importance for the membership.

Committee members

Chairperson Harrold T. Elberfeld, M.D.

Cawas M. Antia, M.D.

Joyce M. Boyd, M.D.

Rudiger Breiteneker, M.D.

Harold D. Gabel, M.D., M.P.H.

Phillip J. Goldstein, M.D.

John A. Hawkinson, M.D.

Juanito F. Lopez, M.D.

Russell W. Moy, M.D.

David A. Nagey, M.D.

J. Courtland Robinson, M.D.

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Liaison Committee with the Medical Assistance Program

Mr. President and Members of the House of Delegates:

During the 1993-1994 annual year, the Liaison Committee with the Medical Assistance Program addressed many issues related to the practices of many of Med Chi physicians.

Many of the Maryland Medical Assistance Program transmittals, alerts, and memos were reviewed. Although the committee felt a good percentage were for information only, several were of concern. Members of the Medical Assistance Program, Department of Health and Mental Hygiene (DHMH), were invited to attend a meeting to discuss many of the committee's concerns regarding the information received from the Medical Assistance Program. Of particular concern to the committee was the "Update of the Less than Effective Drug Products effective June 15, 1993." Committee members were concerned about the criteria used to place a drug on this list.

The memorandum regarding the "Evaluation of Coverage of Extemporaneously Compounded Prescriptions" was also of concern to the committee. The committee asked the DHMH to look into the possibility that there was a pattern of abuse of extemporaneously compounded drugs among

only a few nursing homes. The committee was briefed by members from DHMH, who reported:

- ♦ of the 4,923,932 prescriptions paid for in fiscal year 1993, 16,182 (0.3%) were compounds;
- ♦ although compounds account for 0.3% of all prescriptions, in nursing homes only, they are three times more prevalent (0.9%);
- ♦ nursing homes accounted for 9,174 (57%) of the 16,182 compounds;
- ♦ of the 9,174 nursing homes, 14 accounted for 5,874 (64%) of the compounds;
- ♦ of the 16,182 compounds, 7,143 (44%) were written by 15 prescribers (10 nursing homes, 2 hospitals, and 3 individuals);
- ♦ of the 16,182 compounds, 8,055 (50%) were filled by 3 pharmacies.

The committee noted that the normal extemporaneously compounded drugs are dermatological drugs. It was suggested that this situation be referred to the Drug Utilization Review Board. A letter was written to the secretary of

DHMH and the director of the Medical Compliance Administration recommending that they target outliers for education where appropriate for those who were prescribing extemporaneous drugs unnecessarily.

Several letters were referred to the committee from Med Chi members regarding cross-over claims. Members of DHMH were invited to discuss this issue with the committee. DHMH representatives noted that crossover claims are paid within four weeks and that DHMH pays 70,000 claims a day. The average time to pay a claim is 20 days, down from 30 days last year. DHMH noted that 99% of the claims not paid in a timely fashion were due to incorrect information placed on the 1500 form. DHMH also stated that there were not many problems with the codes being used incorrectly. DHMH stated that the filing time limitation was nine months and that DHMH medical assistance program pays more quickly than private insurers. DHMH has few problems with claims from BlueCross BlueShield not crossing over and they stated that paper claims no longer have a backlog. DHMH representatives did state that they were unable to develop a program to accept coding on the 1500 form.

Concerns with the Maryland Access to Care (MAC) program were also discussed. Committee members discussed their experiences with MAC patients and noted that many were irresponsible and child-like in their behavior. Members found that it was important to get the patients to like the physician before they would become responsible and visit the physician at set times and not just when they felt like it. The committee emphasized the importance of slowly educating MAC patients to be more responsible.

Also discussed were inquiries from various physicians regarding HMOs that enroll MAC program participants. While physicians participating in the MAC program do not receive capitation fees, HMOs do. The committee discussed their experiences with HMOs taking over MAC patients.

Inequities in the drug list for a 100-day supply were discussed. It was noted that in many ways the ruling is irrational and could cause increased physician visits, as well as patients' skipping office visits, running out of medication, and becoming acutely ill, which would add to the cost of the medical assistance program. The matter was referred to the Executive Committee. Members from DHMH noted that this was an FDA list. The FDA gives DHMH a list of identical, related, or similar drugs. Since DHMH cannot distribute the list as quickly as it is received, DHMH has requested that the FDA supply DHMH with a list in alphabetical and numerical order. DHMH representatives were not sure what they could do to make the list clearer.

The committee asked the Council to approve a resolution to be sent to the AMA asking the FDA to explain the criteria

used to formulate the DESI list. The Council approved the resolution for submission to the AMA.

The committee would like to thank all members who brought issues and concerns to the committee's attention during this last year.

Committee members

Chairperson Joseph Zebley, M.D.

Paul Burgan, M.D.

Carol W. Garvey, M.D.

Irvin B. Kaplan, M.D.

Margaret Snow, M.D.

Reed A. Winston, M.D.

Advisory members

Joseph W. Millstone, DHMH Health Systems

Lawrence Triplett, DHMH Medical Care



William Richardson, Ph.D., updates Med Chi members on the activities of the Health Care Access and Cost Commission during the House of Delegates Meeting on July 21, 1994.

Medical Care Database Development Technical Advisory Committee

Mr. President and Members of the House of Delegates:

The Medical Care Database Development Committee is one of the newly formed Med Chi technical advisory committees. These TAC groups were formed to keep the Med Chi membership informed of the developments of important health issues being addressed at the state level. The chairperson of the Med Chi TAC is Joseph Fastow, M.D. Dr. Fastow is also a technical advisor to the Maryland State Database Development Work Group and has served as a panelist representing Med Chi at several of its meetings.

The Maryland Database Development Work Group began its work by researching data systems that have been developed in other states. Various interested groups gave their input regarding their expectations of a statewide medical information database with the general starting

point being a claims-driven database system based on the HCFA 1500 reporting form that is required of all physicians.

For the upcoming year, the committee plans to continue to be involved in the development of the new system and the implementation of available technology to facilitate such computerization.

Committee members

Chairperson Joseph S. Fastow, M.D.

Dino Flores, M.D.

Joseph W. Berkow, M.D.

Alberto C. Seiguer, M.D.

Cecilia S. Schocket, M.D.

Ralph L. Wroth, M.D.

Alan Wright, M.D.

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Committee on Medicine and the Performing Arts

Mr. President and Members of the House of Delegates:

During the 1993-1994 year, the Committee on Medicine and the Performing Arts met twice. Members worked independently on a new newsletter project designed to educate the physicians of the state, as well as other local health and performing arts professionals, and to keep the committee and its activities before the public.

After a great deal of discussion, the committee decided that the day and a half regional conferences should be held biennially. The committee has hosted three conferences or seminars in the last two years and has participated in each Med Chi annual meeting during its five years of existence. There was some concern that the number of local experts might currently be too small and the topic might become overexposed. However, the committee did not want to lose touch with its base of support or stop its educational efforts.

The newsletter will fulfill these goals, as well as give committee members from outside the metropolitan area a

way to contribute. The first issue of *Cues, Clues and News: a Performing Arts Medicine Newsletter* was sent out in April. It contained contributions from committee members on topics ranging from carpal tunnel syndrome to vocal premenstrual syndrome. There were also columns on recent publications and upcoming conferences.

The committee has received positive response from the local arts medicine community, with several people asking to be on the mailing list and one person offering to serve on the committee. Two or three more issues of the newsletter are planned for 1994. The newsletter initially was designed only for non-conference years. Depending on reader response, it may continue indefinitely.

An exciting event for the committee occurred when the Music Medicine Clearinghouse bibliographies became available online as part of a pilot project from the Maryland State Library Network. The project, named Puppy, will eventu-

ally tie together all public libraries and as many academic and special libraries as possible in the state. Online library catalogs, community information and referral directories, state government information, and many other items will be available to any citizen with access to a computer and modem.

Puppy also provides a connection to some of the free resources of the Internet. Through this connection, arts medicine experts from anywhere in the world could potentially access the bibliographies. The committee is very proud to be part of this project, which puts Maryland in the forefront of national involvement with the "information superhighway."

Copies of the Music Medicine Clearinghouse factsheet and the bibliographies were available at the "Medical Problems of Musicians and Dancers" symposium in Aspen, Colorado, in July. Short articles about the clearinghouse appeared in the *Newsletter of the Maryland Association of Health Sciences Librarians*, *Baltimore Chapter Bulletin* (Special Libraries Association) and in *Peabody News*. The committee continues to receive requests for bibliographies and photocopies from all over the nation, as well as several foreign countries.

During the next year, the committee will hold another regional conference. A unique concept, combining music

master classes with clinical rounds, has already been approved by the Committee on Scientific Activity. Since past conference registrants valued very highly the information received from performing artists, the committee will make the master class and clinic an integral part of the 1995 conference.

Committee members

Chairperson John B. De Hoff, M.D., M.P.H.
Federico G. Arthes, M.D.
Emidio A. Bianco, M.D.
Jeffrey W. Bitterman
Bernard Filner, M.D.
Ibiza Nevares, M.D.
Richard Noris, M.D.
Leo M. Rozmaryn, M.D.
Lew Schon, M.D.

Advisory members

Sandra Bishop, M.D.
Ruth Drucker
David Fetter
Lawrence A. Funt, D.D.S.
David Shulman, R.P.T.

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DONALD H. DEMBO, M.D., 1994-1995 Med Chi president, PRESENTS JOSEPH SNYDER, M.D., 1993-1994 Med Chi president, with the past president's plaque during the presidential banquet at the annual meeting.

Committee on Medicine and Religion

Mr. President and Members of the House of Delegates:

The Committee on Medicine and Religion is charged with maintaining liaison and effective lines of communication between physicians and clergymen, leading to the most effective care and treatment of patients and their families. The committee is also responsible to be available to theological seminaries for similar assistance.

Once again, the committee held its annual prayer breakfast at Med Chi's annual meeting. The featured speaker for the breakfast was M. Roy Schwarz, M.D., senior vice president for medical education and science, American Medical Association. His presentation, "The Current Imperative for an Ethical Renaissance in Medicine," addressed the problems of ethical misconduct within the medical profession and its impact on the physician/patient relation-

ship. The talk also explored the question of the credibility of physicians and physician leadership on biomedical ethical issues and possible solutions to these problems. Dr. Schwarz's presentation was very well received by his Maryland peers.

Committee members

Chairperson Leslie R. Miles, Jr., M.D.
Merrill I. Berman, M.D.
Robert E. May, M.D.
Edward T. Schnoor, M.D.
Margaret T. Snow, M.D.
Rhodora C. Tumanon, M.D.
Gibson J. Wells, M.D.

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Committee on Mental Health

Mr. President and Members of the House of Delegates:

The Committee on Mental Health met seven times in the past year. Prominent issues on the committee's agenda were health reform initiatives and their impact on delivery of mental health services. Concerns were raised about noted trends such as the increasing reliance on nonphysician psychotherapists to provide lower cost services, increasing utilization of pharmacological interventions without proper consideration of indications for therapy, and access to psychiatric services under minimal health insurance plans.

These issues, as well as the reactions of Med Chi and other advocates for the mentally ill, were monitored throughout the legislative session.

Also monitored and discussed at length were substance abuse initiatives in Baltimore City. Of particular note was the city's desire for legislation allowing a needle exchange program to be used as a tool in the public health offensive against AIDS.

Committee members

Chairperson Lino Covi, M.D.
Arnold Brenner, M.D.
Edward L. Suarez-Murias, M.D.
Ronald J. Taylor, M.D.
Leonard M. Zullo, M.D.

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Peer Review Committee

Mr. President and Members of the House of Delegates:

The Peer Review Committee is charged with "reviewing the practices of Maryland physicians as referred by the Peer Review Management Committee upon the request of the State of Maryland Board of Physician Quality Assurance ... for the purpose of evaluating the professional, physical, and mental competency of physicians. This review shall include, but not be limited to, the quality of care rendered and shall be conducted within the guidelines set forth in the Peer Review Handbook."

In furtherance of this charge, the Peer Review Committee prepared over 70 peer review reports during its 1993-1994 term pursuant to referrals from the Board of Physician Quality Assurance (BPQA) through the Peer Review Management Committee. Numerous meetings were held, including both full committee and subcommittee meetings.

Committee members and other physicians also contributed to the work of the committee by reviewing and reporting on charts and by conducting office evaluations. The work of the members does not end with the conclusion of the committee's investigation, since additional record reviews and meetings with members of the attorney general's staff to prepare cases for legal action also may be required. The seriousness of the cases referred to the committee is evidenced by the fact that approximately one third of the physicians on whom reports were prepared in calendar year 1993 were referred by the BPQA to the office of the attorney general to be charged with violation of the Medical Practice Act based on the peer review report. The committee continues to be concerned with improving the speed with which peer reviews are conducted and reported back to the BPQA, while preserving both fairness and quality in the review process.

The committee regularly uses nonmember physicians as specialty consultants in each review. Therefore, the committee needs additional reviewers and welcomes any volunteers who wish to assist in this important work.

The chairperson thanks the dedicated members of this committee, our many specialty consultants, and the Med Chi staff for their support and assistance during this past very busy year.

Committee members

Chairperson James W. Karesh, M.D.
Vice-chairperson Henry J. Farkas, M.D.
Fritz Apollon, M.D.
Paul Burgan, M.D.
David M. Cook, M.D.
Augusto R. DeLeon, M.D.
Anand M. Dhanda, M.D.
John G. Frizzera, M.D.
Bernard Heckman, M.D.
Victor Hrehorovich, M.D.
Tah-Hsiung Hsu, M.D.
Charles W. Kinzer, M.D.
James C. Kleeman, M.D.
Alfred L. Lapin, M.D.
M. Isabelle MacGregor, M.D.
Reynaldo P. Madrinan, M.D.
Raymundo S. Magno, M.D.
George Malouf, Jr., M.D.
Stanley Minken, M.D.
Ronald J. Orleans, M.D.
Gary M. Roggin, M.D.
Elie A. Sayan, M.D.
William I. Smulyan, M.D.
Larry A. Snyder, M.D.
Paul D. Sullivan, M.D.
Donald W. Wiczer, M.D.

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Peer Review Management Committee

Mr. President and Members of the House of Delegates:

The Peer Review Management Committee (PRMC) has continued its function of overseeing the peer review process as specified in the *Peer Review Handbook for Maryland* (the handbook). The committee meets monthly and is responsible for the following:

- ♦ receiving and recording cases referred to Med Chi by the Board of Physician Quality Assurance (BPQA);
- ♦ identifying the guidelines used in conducting the review;
- ♦ referring cases to the appropriate medical review committee;
- ♦ developing and maintaining a monitoring procedure allowing for the immediate determination of the status of a peer review complaint and ensuring that the review is completed in a timely manner;
- ♦ reviewing reports received from investigating committees to determine their adequacy;
- ♦ identifying the inadequacies in writing and returning a report to the review committee in the event the committee finds a report inadequate;

- ♦ transmitting adequate reports to the BPQA;
- ♦ forwarding a copy of final disposition reports received from the BPQA to the appropriate medical review committee;
- ♦ identifying areas in which medical review committees need education and arranging to have the necessary education provided;
- ♦ providing organizational assistance to any medical review committee in Maryland; and
- ♦ periodically meeting with the BPQA to decide what kinds of statistical information are needed by the BPQA, Med Chi, and component societies to aid in evaluating and upgrading the review process.

The PRMC sought to improve the peer review process by educating peer review groups regarding the guidelines established in the handbook for the conduct of review activities. Education occurred by visiting local and specialty society peer review committee meetings and by PRMC insistence that all reports be in compliance with handbook guidelines before approval for transmission to the BPQA. PRMC representatives also regularly attend BPQA meetings.

The chairperson thanks all the members of the committee and the Med Chi staff and also the members and staff of all Med Chi and component peer review committees for their efforts and support, which enabled the PRMC to make a significant contribution to the efficacy and fairness of the review process.

Committee members

Chairperson Ronald J. Cohen, M.D.
Pablo E. Dibos, M.D.
Jesse M. Hellman, M.D.
Joseph H. Hooper, M.D.
David S. McHold, M.D.
Mark S. Seigel, M.D.
Navin Shah, M.D.
Martin C. Shargel, M.D.
Karl H. Weaver, M.D.
Herbert L. Yousem, M.D.



ROBERT MCAFEE, M.D., 1994-1995 AMA president, and DONALD "TED" LEWERS, MEMBER OF THE AMA BOARD OF TRUSTEES, LISTEN TO A PRESENTATION DURING THE HOUSE OF DELEGATES MEETING.



Physician/Patient Relations Committee

Mr. President and Members of the House of Delegates:

The Physician/Patient Relations Committee (PPRC) continues to investigate complaints against physicians at the request of the Board of Physician Quality Assurance (BPQA). The committee's findings and recommendations are submitted to the BPQA for consideration and disposition.

In the past year, the PPRC had the responsibility of screening Health Claim Arbitration Office (HCAO) cases received from the BPQA. Since this assignment was made, the PPRC has been meeting monthly to screen HCAO cases. Once reviewed, the PPRC's findings are forwarded to the BPQA, which determines, after considering the findings of the committee, whether the cases require a more extensive peer review.

The dedication and commitment of committee members and staff to the continuation and improvement of the peer review process is deeply appreciated.

Committee members

Chairperson Robert A. Liss, M.D.

Vice-chairperson Norris L. Horwitz, M.D.

Ruben Ballesteros, M.D.

Edilberto Beltran, M.D.

Riad Dakheel, M.D.

David S. Davis, M.D.

Jack D. Francis, M.D.

Mary B. Gorman, M.D.

Gerald A. Hofkin, M.D.

Thomas Hunt, M.D.

Danilo G. Lee, M.D.

Ruben Reider, M.D.

Benjamin Rothfeld, M.D.

Lex B. Smith, M.D.

W. Haddox Sothoron, M.D.

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Committee on Physician Rehabilitation

Mr. President and Members of the House of Delegates:

The Committee on Physician Rehabilitation continued to assist physicians with alcoholism, chemical dependence, psychiatric disorders, problems related to organicity, and sexual abuse.

In 1993, the Physician Rehabilitation Program received concern calls on 146 physicians, the highest number of referrals ever. Identified problems on referral included: alcoholism (30%); chemical dependence (38%); dual diagnosis (alcoholism/chemical dependence and psychiatric problems, 7%); psychiatric disorders (17%); physically based problems with emotional sequelae (5%); sexual misconduct (13%); stress (3%); and legal problems (9%). In 16% of cases, no problem was identified on referral. Fifteen referrals for Focused Professional Education evaluations were received in 1993; 86% of cases were male, 14% were female. Committee and staff conducted 671 individual contacts and over 2,000 phone contacts with physician participants. In addition, 1,600 urine drug screen contacts were conducted.

During the latter part of 1993, the committee began improving the quarterly publication, *Straight Forward*. Improvements have included using original articles almost exclusively and dedicating each issue to a particular topic (e.g., legislative matters, addiction problems in anesthesiologists). Future issues will focus on such topics as transitions in medicine, sexual abuse, and litigation stress. Many compliments have been received on the new format. Also in the publication area, the pamphlet *Medical Treatment Never Includes Sexual Contact* was distributed with the Board of Physician Quality Assurance (BPQA) Newsletter and mailed to every physician in Maryland. Many compliments on this effort were received as well.

In January 1994, the Physician Rehabilitation Program was featured on *Straight Talk*, a half-hour program that aired on Channel 45. The show reviewed the Physician Rehabilitation Program, featured recovery stories, and highlighted the committee's work on the issue of sexual miscon-

duct in a physician's office. The program was made available to local college stations for rebroadcast. Stanley R. Platman, M.D., chairperson; Patricia McIntyre, M.D., committee member; Craig Martin, M.D., Maryland Psychiatric Society; two anonymous recovering physicians; and Michael C. Lufrio, NCAC II, director, Physician Rehabilitation Program, appeared on the show.

During the 1993 legislative session, a bill was passed that required state legislative auditors to review the peer review and physician rehabilitation programs. Between August 1993 and January 1994, auditors meticulously reviewed financial and clinical records to perform both fiscal and performance audits. The performance audit showed that the program is well run, efficient, and accomplishing its mission. The only area where auditors recommended improvement was follow-up. Since that time, Med Chi has hired a part-time data analyst to conduct follow-up for the program.

On December 11, 1993, the Physician Rehabilitation Committee held its fourth annual conference on addiction at the Sheraton BWI Conference Center. Over 150 physicians and other health care professionals attended. Presentations included "Biomedical Aspects of Addiction and Nicotine Dependence" by Max Schneider, M.D.; "The Nature and Status of Drug Abuse Treatment" by David Nurco, D.S.W.; "Opioid Abuse" by Joseph Gagliardi, M.D.; "Access to Treatment" by the Honorable Harold E. Hughes; "Helping the Helpers" by Father Joseph Martin; and "National Drug Control Policy" by John Gregrich. The conference was well received by attendees. A monograph containing the conference presentations was published to educate physicians and other health care practitioners on substance abuse, physician health, and government policy on drug issues. The committee looks forward to presenting the fifth annual conference, "Healing the Total Person," in November 1994.

On a sad note, 1993 was marked by the loss of two valued committee members and friends, Edward Kitlowski, M.D., and Maxie Collier, M.D. They are sorely missed.

The committee continues to assist physicians with problems of living that have impaired or may in the future impair their ability to practice. The chairperson wishes to thank committee members and staff for their hard work and dedication.

Committee members

Chairperson Stanley R. Platman, M.D.
William E. Abramson, M.D.
Frederick P. Alpern, M.D.
Frederico H. Arthes, M.D.
Leroy C. Bell, M.D.
John W. Blenko, M.D.
Mrs. Anne Bolen
Nathan L. Centers, M.D.
*Maxie T. Collier, M.D.**
Morris A. Effron, M.D.
Beadah H. Hill, M.D.
*Edward J. Kitlowski, M.D.**
Christie G. Lamping, M.D.
Philip H. Lavine, M.D.
Robert M. Marine, M.D.
Dan H. McDougal, M.D.
Patricia A. McIntyre, M.D.
Donald C. Meek, M.D.
Edson B. Moody, M.D.
Claro Pio Roda, M.D.
Edward T. Schnoor, M.D.
John R. Steinberg, M.D.
Maxwell N. Weisman, M.D.

* deceased

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Committee on Professional Ethics

Mr. President and Members of the House of Delegates:

The Committee on Professional Ethics continued throughout 1993 and 1994 to carry out its responsibility to provide advice and maintain the high standards of ethics characteristic of the practice of medicine in Maryland. The committee also reviewed and granted approval to a substantially increased number of professional corporate names, due to the passage of legislation in 1993 making it much easier for

physicians to establish professional corporations with non-personal names.

The committee conducted a general review of the *Compendium of Laws, Regulations, Opinions and Policies Governing the Practice of Medicine in Maryland* and concluded that a substantial revision is necessary due to the enactment of new health system reform legislation, self-referral legis-

lation, and health care decision legislation. As a result, the general counsel was requested to begin the process of revision, to be approved by the committee. That process is now ongoing.

In response to national publicity generated by the activities of Dr. Jack Kevorkian, the Maryland attorney general's office prepared a bill for submission to the 1994 session of the General Assembly that would have made it a felony for a person to assist another person to commit suicide, with certain definitional exceptions. The committee recognized that the AMA has ethically condemned the practice of physician-assisted suicide and the committee reaffirmed this ethical position. The committee refused to support the bill, however, because of concerns that a misreading of the bill could impose criminal liability on psychiatrists and other physicians in situations where such criminal responsibility would be entirely inappropriate. The committee passed this recommendation on to the Legislative Committee during the legislative session, resulting in the Legislative Committee's adopting a position opposing this proposed legislation. The bill did not pass the General Assembly.

In early 1994, the Frederick County Department of Education wrote to Med Chi seeking advice on a difficult question regarding a "do not resuscitate" (DNR) order that had been made applicable to a pupil who was terminally ill. After reviewing the pertinent AMA ethical opinions, the Professional Ethics Committee rendered its opinion that if

the DNR order is issued by a competent physician who has evaluated the patient and stated that from a medical standpoint the wishes of the family should be adhered to, then the order should be complied with by representatives of the school system. It was felt that the evaluation should be appended to the DNR order.

The committee will continue its existence during the 1994-1995 year as an integral part of the Council on Professional Ethics that has been brought into existence under Med Chi's new bylaws. The members look forward to continuing this vital work on behalf of the physicians of Maryland.

Committee members

Chairperson Leslie R. Miles, Jr., M.D.
Edilberto Beltran, M.D.
Jack C. Childers, Jr., M.D.
Beverly A. Collins, M.D.
Seymour Goldgraben, M.D.
Eugene Guazzo, M.D.
Joseph H. Hooper, M.D.
Benjamin Rothfeld, M.D.
Henry J. Silverman, M.D.
Margaret T. Snow, M.D.
A. Carl Segal, M.D.
Jack M. Zimmerman, M.D.

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PRO Monitoring Committee

Mr. President and Members of the House of Delegates:

In September 1993, beginning this year of its operations, the PRO Monitoring Committee was addressed by Christian Jensen, M.D., then-medical director of the Delmarva Foundation for Medical Care, who presented information on the foundation's Fourth Scope of Work. Dr. Jensen also showed a videotape from HCFA on the new health quality improvement initiative. Dr. Jensen reported that the Fourth Scope of Work was at that point four months into its fulfillment, and he described the Fourth Scope of Work in detail, suggesting that its implementation would substantially change the prior, sometimes-adversarial relationship be-

tween physician and PRO. He added that individual case review would continue henceforth, but at a reduced level, and that final letters in the cases of confirmed quality problems would be exclusively educational in content.

During the year, the DEMPAQ project came to completion and its report was reviewed by the PRO Monitoring Committee. Committee member Dr. Sheldon Goldgeier presented a detailed explanation of the DEMPAQ project presentation, and the committee decided that a request should be made to Dr. R. Heather Palmer, director of the Center for Quality of Care Research and Education of the

Harvard School of Public Health, for an article on the DEMPAQ project to be submitted to the *Maryland Medical Journal*.

The committee also reviewed the URAC's National Utilization Review Standards and accepted them with recommendations for additional development governing reimbursement issues.

Committee members

Chairperson Augusto R. Deleon, M.D.
Marion Friedman, M.D.
Vernon M. Gelhaus, M.D.

Roland V. Goco, M.D.
Sheldon Goldgeier, M.D.
Howard J. Hoffberg, M.D.
Zorayda M. Lee-Lacer, M.D.
John B. MacGibbon, M.D.
Robert Ruderman, M.D.
Karl H. Weaver, M.D.

Advisory member

Rose Matricciani, R.N., J.D.

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Committee on Public Health

Mr. President and Members of the House of Delegates:

During 1993-1994, the Committee on Public Health focused its efforts on domestic violence and tobacco control.

The committee worked closely with the Maryland Alliance Against Family Violence to develop the Maryland Physicians' Campaign Against Family Violence. The effort began with the following recommendation, endorsed by the Executive Committee and Council: that Med Chi support the efforts of the Maryland Alliance Against Family Violence and include \$25,000 targeted toward physician education and to support legislation to be more friendly towards physicians who report family violence.

The money earmarked by Med Chi, along with additional funds from the state Department of Human Resources, Department of Hygiene and Mental Health, and a federal grant, allowed the committee to develop a two-credit CME training curriculum for physicians. The curriculum, modeled on the Ohio Domestic Violence Project, was reworked with the permission of the Ohio Medical Society to be Maryland specific. On May 20 and 21, workshops were held to train physicians and other health professionals who will be bringing the program to hospitals across the state. The curriculum was also mailed to all physicians statewide.

Sessions on domestic violence were held at the semiannual and annual meetings to increase physician awareness. Also, the April 1994 issue of *Maryland Medical Journal* was devoted entirely to family violence and child abuse.

In conjunction with the Coalition for a SmokeFree Maryland, Med Chi submitted a grant application to the Robert Wood Johnson Foundation's SmokeLess States Project. If

received, the grant will be used to define a governance structure for the Coalition, establish a tobacco control clearinghouse at Med Chi, and develop a larger grassroots base for tobacco control issues.

The Public Health Committee also recommended, and the Executive Committee and Council approved, the endorsement of the principles of the coalition:

- ♦ Children should be protected by enforcement of laws against selling tobacco to minors.
- ♦ Children should be protected by limiting the placement of tobacco vending machines.
- ♦ Employees should be protected by law in their right to a smoke-free work environment.
- ♦ The public should be protected by making enclosed public places free of environmental tobacco smoke.
- ♦ The state should not preempt counties and municipalities from enacting stronger legislation.
- ♦ The state should increase taxes on all tobacco products.

The committee continued to be the oversight committee for the following subcommittees: Immunizations and Infectious Diseases Subcommittee; Infant, Child, and Adolescent Health Subcommittee; Maternal Welfare Subcommittee; and Sports Medicine Subcommittee.

Committee members

Chairperson Martin P. Wasserman, M.D.
Robert J. Ancona, M.D.
Timothy Baker, M.D.

Alan D. Bedrick, M.D.
Joyce M. Boyd, M.D.
Beverly A. Collins, M.D.
John B. De Hoff, M.D.
Harrold T. Elberfeld, M.D.
Vincent J. Fitzpatrick, M.D.
Harold D. Gabel, M.D.
Carol W. Garvey, M.D.
Nelson G. Goodman, M.D.

David L. Kreisberg, M.D.
J. Courtland Robinson, M.D.
Joseph W. Zebley, M.D.

Advisory member

Rose M. Matricciani, R.N., J.D.



Public Relations Committee

Mr. President and Members of the House of Delegates:

During the 1993-1994 year, the Public Relations Committee continued its involvement with several programs and continued to evaluate the public relations needs of Med Chi.

Family violence. 1993-1994 marked the beginning of a comprehensive initiative against family violence. The Public Relations Committee, in conjunction with the Com-

mittee on Public Health and the Maryland Alliance Against Family Violence, held a press conference on September 8, 1994, to announce the Maryland Physicians' Campaign Against Family Violence. (Further information about this initiative is contained in the report of the Family Violence Task Force.) This campaign is designed to educate physicians and other health care professionals about family violence issues. Through its educational efforts, the campaign will increase the awareness among physicians that family violence is a public health issue and encourage physicians to assume a leadership role in eliminating family violence.

To educate physicians about family violence, the Public Relations Committee and the Committee on Public Health cosponsored a seminar entitled "What Can You Do About Family Violence?" at the 1993 semiannual meeting. These two committees also cosponsored a seminar entitled "Families Under Siege – Physicians' Role in Combating Family Violence" at the 1994 annual meeting. This presentation featured Robert McAfee, M.D., then president-elect of the AMA and a leader in the AMA's campaign against family violence.

To publicize this campaign, Dr. Nakazawa, chairperson of the Public Relations Committee, Dr. Wasserman, chairperson of the Committee on Public Health, Roseanne Matricciani, chief operating officer of Med Chi, and Joanne Tulonen, executive director of the Maryland Alliance Against Family Violence, met with a reporter from the *Catholic Review*. The paper published an article entitled "Doctors Group Launches Campaign to Unlock the Silence of Family Violence" on the front page of its February 9, 1994 issue.



HIROSHI NAKAZAWA, M.D., 1993-1994
CHAIRPERSON OF THE PUBLIC RELATIONS
COMMITTEE, ADDRESSES THE HOUSE OF
DELEGATES AT THE 1994 ANNUAL MEETING.

The committee will continue to work with the Family Violence Task Force throughout the campaign's other two phases—child abuse and elder abuse.

Partnership program. The committee continued its work with the Doctor/Lawyer/Teacher Partnership Against Drugs, a community service program through which doctor/lawyer teams visit local middle schools and discuss the medical and legal ramifications of drug use with the students. In October, a press conference was held to announce that this statewide program had received an \$88,000 grant from the Governor's Drug and Alcohol Abuse Commission. In January, the committee sponsored a training session at Med Chi for physicians and lawyers. During this training session, physicians were given posters and other materials to use during their presentations to the students. The program continued to grow this year, with doctor/lawyer teams visiting schools throughout the state.

Radio program. In January, Med Chi joined the "Sunday Rounds" radio program on WBJC (91.5 FM). "Sunday Rounds" is a live, call-in program that airs every Sunday evening. Med Chi has a one hour segment (7:00 p.m. to 8:00 p.m.) of this program every other week. Med Chi members have appeared on the program to discuss a variety of health-related issues, including sleep apnea, strokes, diabetes, child abuse, and the Patient Access Bill.

Awards. The committee continued to sponsor its awards programs. The Wyeth-Ayerst Laboratories Physician Award for Community Service was presented during the annual meeting to Frank A. Pedreira, M.D. Dr. Pedreira received the award in recognition of his involvement in a wide range of community service activities, including his work with soup kitchens, adult education projects, and Life International, a program that sponsors navy ships for use as floating hospitals in third world countries.

The committee sponsored the Fourteenth Annual Photo Contest. Photos were judged by Barbara Brown, a professional photographer. The photo "Glistening Tower" taken by Alan V. Abrams, M.D., won first place, and the photo "Bleeding Heart" taken by Michael Liteanu, M.D., won second place.

Winners of the Eighth Annual Media Awards Program were Susan Thornton for her article "The Vanishing Mind," a story that appeared in the *Columbia Flier* about a couple's struggle with Alzheimer's disease; Diane Brown for her article "I Can Hear," which also appeared in the *Columbia Flier* and described how a boy's hearing was restored through a cochlear implant; and John Stupak for a radio program entitled "Physician-Assisted Suicide."

During the House of Delegates meeting at the 1994 annual meeting, certificates of recognition were presented

to four physicians for their outstanding dedication as Med Chi committee chairpersons: Ronald J. Cohen, M.D., chairperson of the Peer Review Management Committee; Martin P. Wasserman, M.D., chairperson of the Committee on Public Health; J. Ramsay Farah, M.D., chairperson of the HMO Quality Care and Practice Parameters Technical Advisory Committee; and Hilary T. O'Herlihy, M.D., chairperson of the Legislative Committee.

Professional public information campaign. The committee reviewed proposals for public relations services from two public relations/marketing firms: MWM/Strategic Communications and Capital Communications Strategies. Due to the costs outlined in these proposals, the committee determined that it should continue meeting with other communications firms to determine whether a less costly communications program could be implemented, and should continue to enhance the in-house communications program.

Patient education campaign on health insurance plans. In March, the committee began developing an educational campaign to inform people about various managed care plans (HMO, PPO, IPA, etc.). To begin this program, the committee developed a brochure on managed care plans. The committee will continue working on this program during 1994-1995.

Committee members

Chairperson Hiroshi Nakazawa, M.D.
 Vice-chairperson Andrew P. Fridberg, M.D.
 Gregoria Belloso, M.D.
 Mark D. Chilton, M.D.
 K.G. Dritsas, M.D.
 Vincent D. Fitzpatrick, M.D.
 Rafael C. Haciski, M.D.
 Christian Jensen, M.D.
 Thomas F. Krajewski, M.D.
 Arnold G. Levy, M.D.
 Chris Papadopoulos, M.D.
 Gholam R. Sadjadi, M.D.

Advisory members

Fred Magaziner, D.D.S.
 Jackie Chang

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Retreat Committee

Mr. President and Members of the House of Delegates:

Based on an analysis of data collected from a series of individual interviews, the Retreat Committee identified the issues most critical to Med Chi's success and worked in small groups to develop ideas for improving performance in each area. After reviewing the ideas presented by each of the groups, the entire Retreat Committee designated seven major areas in which to propose improvements. Each topic area is the special domain of one or more "champions" whose duties will be to assure timely follow-up on action items.

The topic areas identified for improvement are:

- ♦ Mission: revise the statement of purpose for greater focus and clarity.
- ♦ Governance and Structure: simplify structure and streamline decision making.
- ♦ Executive Leadership: prepare job description, establish performance criteria, provide regular evaluation and feedback.
- ♦ Political Infighting: stop internal rivalries and focus on external challenges.
- ♦ Issues Focus: create means to identify and address critical issues in a timely and effective manner.
- ♦ Communication and Inclusion: improve overall communication, and respect and enhance the role of the component societies.
- ♦ Ongoing Mechanisms for Evaluation: continuously monitor performance and responsiveness to member and public demands.

Task group recommendations were developed and specific proposals for action were presented and reviewed at a meeting of the Retreat Committee on January 11, 1994. The Retreat Committee assumed responsibility for planning and managing the change process, which it hopes to move along as rapidly as possible consistent with obtaining sufficient support throughout the organization.

Summary of Med Chi Retreat

Pursuant to a resolution of the Med Chi Council at its September 1993 meeting, a retreat was held November 20 and 21, 1993, to examine the mission, structure, and operation of Med Chi relative to the demands of physicians, patients, and the general public in the coming decade. The

committee's 18 participants were selected with a view to appropriate representation by geography, age, gender, race, and experience. Expenses for the retreat were paid by the Med Chi Agency, whose director of operations, Ronald Fisher, also participated in the retreat. Dr. Allan Jensen chaired the retreat.

The retreat was facilitated by Frederick P. Nader and Victoria Scott of Maryland-based Capital Consulting Group, Inc. (CCG). In preparation for the retreat, the facilitators collected pertinent data through interviews with 45 Med Chi members and staff; legislators and public officials; executives of component societies, AMA, and other state medical societies; and senior members of related health care industry organizations. To encourage candor and honesty, the interviews were conducted with the understanding that the information would not be attributed to individual sources.

Following a discussion of the purposes and ground rules for the retreat, Fred Nader reviewed the basic requirements for effective organizational performance. He then presented a summary of the interview data, discussed the organizational implications, and asked the retreat participants to identify the issues most critical to the success of Med Chi. Once the priority items were identified, smaller task groups were created to discuss these key issues and develop a suggested course of action. For each issue, the Retreat Committee nominated one or more "champions," i.e. people who would:

- ♦ make sure there was effective and timely follow-up on action items;
- ♦ report recommendations to, and work closely with, appropriate organizational bodies;
- ♦ get broad input and buy-in from members; and
- ♦ ensure the implementation of approved changes.

In some instances, issues thought to be significant in their own right were combined with related issues, but retained their own "champions."

It was unanimously agreed that the full Retreat Committee assumed responsibility for planning and managing the organizational change process, with such support as may be required from Med Chi staff and CCG. The plan was to move as rapidly as possible consistent with obtaining widespread support throughout the organization.

Key Issues

Mission

Champions: Donald H. Dembo, M.D., and Willie Blair, M.D. Proposed modifications to the mission to achieve greater focus would be crafted into a new Statement of Purpose to be reviewed by members of the task group and referred to the Executive Committee in time for discussion at the December 16, 1993 meeting.

Governance and Structure

Champions: Allan D. Jensen, M.D., Joseph Snyder, M.D., Donald H. Dembo, M.D., Louis Breschi, M.D., and Rose Matricciani, R.N., J.D. Recommendations to simplify the organizational structure, make it possible for members to become more informed and involved, and streamline decision-making processes would be prepared for discussion at the next meeting of the Retreat Committee on January 11, 1994.

Executive Leadership and Performance Appraisal

Champions: Marianne Benkert, M.D., and Christian Jensen, M.D. A comprehensive job description would be prepared for the position of chief executive officer, together with performance criteria and a plan for regular evaluation and feedback on performance. The chain of command and reporting relationships would also be clarified. Information on the criteria used by other organizations, from sources such as the American Society of Association Executives, would be the starting point, with adaptations made as needed to accommodate the requirements of Med Chi.

Political Infighting

Champions: Willarda Edwards, M.D., Donald H. Dembo, M.D., and Louis Breschi, M.D. The goal of this initiative was to channel energy currently wasted on political infighting and rivalries among component societies into productive responses to external challenges facing the medical community. Fiduciary duties of Med Chi Corporation, its members, and the public must supersede personal interests of any individual or subgroup. Steps necessary to assure this positive change may include: an agreement that such non-productive behavior will be openly confronted; structural changes (see above); and education. Louis Breschi would serve as special champion in the area of ethics related to infighting. Recommendations would be reported to the Retreat Committee on January 11, 1994.

Issues Focus

This area was addressed both at the broad conceptual level and in three specific categories, each with one or more champions.

Conceptual Level Champions: Allan Jensen, M.D., Fred Miltenberger, M.D., Joseph Snyder, M.D., and Carol W. Garvey, M.D. The objective was to ensure that effective structures and processes are in place to identify and address critical issues proactively. Existing structures work against effective and timely discussion and action and waste the time and energy of the leadership, volunteers, and staff. Recommendations would be developed and presented to the Retreat Committee on January 11, 1994.

Legislation and Public Image Champions: Philip Schneider, M.D., Willie Blair, M.D., and Joseph Snyder, M.D. Working closely with lobbyist Jay Schwartz and Med Chi communications director Ruth Seaby, this group recommended a committee structure and process to quickly respond to critical legislative issues and public concerns. A primary objective was to represent effectively the interests of the component societies (and to pursue common interests with subspecialty societies). A report would be made to the Retreat Committee on January 11, 1994.

HMO/IPA Champion: Ronald Fisher. In response to sweeping change proposed in President Clinton's health care reform package, formation of an HMO, IPA, or other physician alliance would be studied, with immediate concentration on the needs and wishes of Maryland physicians and similar structures created in other states. It was understood that a more detailed feasibility study would require a commitment of significant financial and human resources not currently authorized.

Medical/Ethical Issues Champion: Louis Breschi, M.D. Mechanisms to identify significant medical/ethical issues, to lead public and professional dialogue on these issues, and to better serve as medical/technical consultant to the legislature on ethical questions would be recommended at the January 11, 1994, meeting of the Retreat Committee.

Communications and Inclusion

Champion: Philip Schneider, M.D. It is critical to enhance the role of component societies (and subspecialty societies) in Med Chi activities and communications, using technology to maximum benefit while building partnerships and enduring mutual respect through quality work on issues of common interest. Providing a forum for professional dialogue on controversial topics could help establish common ground when a diversity of views within the profession makes total agreement difficult. Immediate improvements will be made through greater use of fax, a voicemail system, and other conventional channels. Recommendations for more far-reaching measures and supporting organizational changes would be presented at the January 11, 1994, meeting of the Retreat Committee. Anticipated benefits include

increased membership and greater credibility of Med Chi in its role as representative of the medical profession.

Ongoing Mechanisms for Evaluation of Organizational Functions, Issue Identification, and Management

Champions: Allan D. Jensen, M.D., Donald H. Dembo, M.D., and Angelo Troisi, F.A.C.H.E. Concern about whether Med Chi is aware of, and capable of adapting to, the changing professional environment was the basis for many of the specific issues discussed. Examples included the handling of legislation (HB 1359), the role of Med Chi in CME, management of peer review and medical-ethical issues, responsiveness to public concerns, and education of the community concerning the important role of physicians. While each of these was addressed specifically and improvements would be made as a result of the organizational restructuring, there is an underlying need to evaluate Med Chi on a continual basis relative to how effectively it is handling these types of demands. Recommendations to accomplish this would be presented at the January 11, 1994, meeting of the Retreat Committee.

Committee members

*Chairperson Allan D. Jensen, M.D.
Marianne Benkert, M.D.
Willie C. Blair, M.D.
Louis C. Breschi, M.D.
Maria L. Del Rosario, M.D.
Donald H. Dembo, M.D.
Willarda V. Edwards, M.D.
Carol W. Garvey, M.D.
James I. Hudson, M.D.
Christian Jensen, M.D.
George Malouf Sr., M.D.
Roseanne M. Matricciani, R.N., J.D.
Frederick Miltenberge, M.D.
Philip L. Schneider, M.D.
Joseph Snyder, M.D.
Donald S. Stepita, M.D.
Angelo J. Troisi, FACHE
Jose M. Yosuco*

Advisory members

*Susan Guarnieri, M.D.
Ronald Fisher*

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HENRY P. LAUGHLIN, M.D., PREPARES TO PRESENT LOUIS L. GOLDSTEIN, COMPTROLLER, STATE OF MARYLAND, WITH THE HENRY AND PAGE LAUGHLIN AWARD FOR CITIZENSHIP AT THE 1994 ANNUAL MEETING.

Committee on Scientific Activity

Mr. President and Members of the House of Delegates:

The committee met six times during the past year and developed educational activities approved for 68.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. These included:

- ♦ The Med Chi semiannual meeting at the Sheraton Hotel in Ocean City (13 hours);
- ♦ "Improving nutrition: Reducing risks related to low birth weight" (1 hour);
- ♦ "Substance abuse education for the primary care physician: An overview of treating the substance-abusing patient" (3 hours);
- ♦ "Substance abuse education for the primary care physician: An overview of treating the substance-abusing patient" (self-study guide, 3 hours);
- ♦ "Anxiety vs. depression: Identification and treatment" (1 hour);
- ♦ "Standards for identifying common infectious diseases" (1 hour);
- ♦ "Pearls of rheumatology" (1 hour);
- ♦ Fourth annual conference on addiction (8 hours);
- ♦ "Mediating medical opinion: Strategies for resolving conflict" (7 hours);
- ♦ "Domestic violence learning retreat" (5 hours);
- ♦ "Maryland physicians' campaign against family violence, module one, domestic violence" (self-study guide, 2 hours);
- ♦ The Med Chi annual meeting at the Ramada Inn and Convention Center in Hagerstown (23.5 hours).

Med Chi is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to plan and present continuing medical education activities, and to designate appropriate activities for Category 1 of the Physician's Recognition Award of the American Medical Association. The ACCME periodically reviews every accredited organization to determine that its program is properly administered. During 1993, Med Chi successfully underwent such a review and received reaccreditation for four years.

It is through the efforts of the entire community that these programs and activities have been so worthwhile and successful. The chairperson wants to take this opportunity to express appreciation to all committee members.

Committee members

Chairperson Victor R. Hrehorovich, M.D.

Benjamin V. Del Carmen, M.D.

Kevin S. Ferentz, M.D.

Jose Martinez, M.D.

Myron I. Murdock, M.D.

Stanley R. Platman, M.D.

Walker L. Robinson, M.D.

Howard M. Silby, M.D.

Associate member

Marianne U. Chiccone, D.M.D.

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Committee on Specialist Identification

Mr. President and Members of the House of Delegates:

The Committee on Specialist Identification held four meetings this past year to implement the mandated specialist identification authority of the Board of Physician Quality Assurance (BPQA). The committee functions as the reviewing body for the BPQA on applications received from physicians requesting designation in a particular medical specialty.

Application for specialty designation is open to all licensed physicians in Maryland. If a physician is certified by the American Board of Medical Specialists, the identification is automatically given by the BPQA upon confirmation of that credential. If not certified by the American Board of Medical Specialists, the physician must complete an application outlining specific training and experience in the particular specialty.

Applications are referred by the BPQA to this committee for evaluation. Criteria used for such evaluation were developed jointly by Med Chi and the BPQA and are set forth in administrative regulations (COMAR 10.32.08) having the force and effect of law. The BPQA makes the final decision on the basis of the recommendation from the committee. The identification is permanent, and the physician may publicize him- or herself in the given area of specialty.

Much time and effort have been exerted in reviewing the 3,250 applications received thus far. Of the applications reviewed, the committee has recommended that 312 be denied. Each application is reviewed thoroughly, fairly, and in strict compliance with the required criteria.

The chairperson wishes to thank the members of the committee for their patience in carrying out this mandated function.

Committee members

Chairperson Samuel D. Friedel, M.D.
Brian S. Bayly, M.D.
William A. Crawley, M.D.
Deusdedit Jolbitado, M.D.
George S. Malouf, Jr., M.D.
Hiroshi Nakazawa, M.D.
John G. Newby, M.D.
Ben Oteyza, M.D.
Arthur W. Sagoskin, M.D.
Mark S. Seigel, M.D.

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Committee on Specialty Societies

Mr. President and Members of the House of Delegates:

The Committee on Specialty Societies met four times during the 1993-1994 year. Its focus was primarily on enhancing communication between Med Chi and the specialty societies and working with Med Chi's HMO Quality Care and Practice Parameters Technical Advisory Committee in identifying specialty-specific practice parameters.

Much discussion took place regarding the perceived needs of the specialty groups to receive timely information concerning Med Chi activities, especially with regard to legislative issues, and for Med Chi to request input from the specialty groups on specialty-specific matters. The committee was informed that the specialty societies are well represented on Med Chi's Legislative Committee and that members of the Committee on Specialty Societies should contact their Legislative Committee representatives with specific comments or concerns about any legislative matter. Members were also informed that they could be placed on the mailing list to receive copies of the newsletter *Legislative Actions*, a weekly publication distributed during the legislative session, and were encouraged to contact their local medical society to receive copies of legislative alerts distributed during the legislative session. In addition, Joseph A. Schwartz, III, Esq., Med Chi lobbyist, addressed the committee stressing the importance of medicine's speaking with one voice. Mr. Schwartz spoke of his intent to meet with

lobbyists from the specialty societies throughout the legislative session to ensure specialty input.

As requested by Med Chi's HMO Quality Care and Practice Parameters Technical Advisory Committee, committee members agreed to supply comments from specialty presidents and respective national specialty societies regarding specialty-specific practice parameters to determine whether the AMA practice parameter guidelines for their respective specialty were suitable for the practice of medicine in Maryland.

Committee members selected to serve as delegates to the House for the 1993-1994 year were Jay Gerstenblith, M.D., Edward J. Goldman, M.D., Abdul Nayeem, M.D., Rafik K. Patel, M.D., Ronald H. Schuster, M.D., Alberto C. Seiguer, M.D., and Allan P. Weksberg, M.D. Daniel E. Kohn, M.D., was elected to serve on Council.

The committee was kept abreast of a number of Med Chi initiatives throughout the year, including Med Chi's independent practice association (IPA) and managed care surveys.

Committee members

Chairperson Daniel E. Kohn, M.D.
Lillian R. Blackmon, M.D.
Paul Bormel, M.D.
Matthew J. Brennan, M.D.

Maurice Furlong, M.D.
 Jay Gerstenblith, M.D.
 Edward J. Goldman, M.D.
 Theodore E. Harrison, Jr., M.D.
 Iredell W. Iglehart, III, M.D.
 Charles J. Lancelotta, M.D.
 Kenneth B. Lewis, M.D.
 Craig M. Martin, M.D.
 Abdul Nayeem, M.D.
 Sean O'Brien, M.D.

Andrew V. Panagos, M.D.
 Rafik Patel, M.D.
 Ibrahim A. Razzak, M.D.
 Donald I. Saltzman, M.D.
 Steven A. Schonfeld, M.D.
 Ronald H. Schuster, M.D.
 Alberto C. Seiguer, M.D.
 Michael S. Shear, M.D.
 Allan P. Weksberg, M.D.

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Sports Medicine Subcommittee

Mr. President and Members of the House of Delegates:

The Sports Medicine Subcommittee is continuing to investigate the feasibility of developing a standardized health history and physical form for all Maryland schools to use for sports examinations. Most county public and private schools currently have their own individual form. The committee is also interested in collecting information concerning required medical representation during school sporting events. A letter was sent to each county/city school board to acquire such information.

To better define committee direction and goals, the committee is surveying component medical societies regarding the activities of their sports medicine committees where they exist. In the meantime, committee members have suggested exploring a number of interesting initiatives. Proposed activities include conducting a presentation at the semiannual meeting to update physicians on sports medicine issues such as steroid use; ascertaining from the Department of Education what sports medicine problems

exist across the state and what funding is available to address these issues; and providing an instructional program to area schools on how to conduct a physical examination for sports.

The subcommittee hopes to expand its activities to include adults and promote overall fitness in general.

Committee members

Chairperson David L. Kreisberg, M.D.
 Neil J. Barkin, M.D.
 Jeffrey W. Bitterman (Student)
 Robert W. Bright, M.D.
 John Gordon, M.D.
 Edward G. McFarland, M.D.
 Lewis McIntyre, M.D.
 Gary W. Pushkin, M.D.
 Myron J. Szczukowski, M.D.

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Standard Benefits Technical Advisory Committee

Mr. President and Members of the House of Delegates:

The Standard Benefits TAC met four times in 1993-1994. In putting together their recommendations to the Health Care Access and Cost Commission, the members of the TAC used as a starting point the benefits outlined by the AMA in the Health Access America plan. This was in keeping with Council's endorsement of the AMA plan. There was some

discussion about slight modifications to the plan that the TAC felt would be in keeping with the goals of freedom of choice, quality of care, and reasonable cost. These modifications were:

- ✦ changing "unlimited hospital days" to "medically necessary hospital days"; and

- ♦ rather than dictating specific intervals for tests and screenings, allowing the physician to decide when they are clinically indicated and medically necessary.

The state working meeting and public testimony sessions were attended by Med Chi staff and reports on the meetings were circulated to the members of the Med Chi TAC. This enabled us to track the development of the benefits plan by the state task force.

The Med Chi proposed standard benefits package was forwarded to the state standard benefits task force on October 21, 1993. Joseph Schwartz, III, Esq., gave testimony to the task force on October 28, 1993. The state standard benefits task force submitted its plan to the Health Care Access and Cost Commission on November 4, 1993. Med

Chi submitted public comment on the final draft on Friday, November 19, 1993.

Committee members

Chairperson Joshua R. Mitchell, M.D.
Vice-chairperson Lawrence Y. Kline, M.D.
Wayne D. Benjamin, M.D.
Marion Friedman, M.D.
Carol Garvey, M.D.
Nelson G. Goodman, M.D.
Susan R. Guarnieri, M.D.
George S. Malouf, M.D.
Joseph W. Zebley, M.D.

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Committee on Therapeutic Education

Mr. President and Members of the House of Delegates:

The Committee on Therapeutic Education met once during the 1993-1994 year. At that meeting, a thorough discussion took place regarding the Department of Health and Mental Hygiene's (DHMH) proposal to stop covering extemporaneously compounded prescriptions when a legend drug is added to an over-the-counter drug to make the over-the-counter drug payable under pharmacy services. The final product frequently is a subtherapeutic or excessive dose of the active legend ingredient. The incidence of such orders is far more frequent for nursing home residents than for recipients residing in the community. Extemporaneously compounded prescriptions also would not be covered when mixing two or more prescription products, which can result in an antibiotic/corticosteroid or cough preparation that is no longer commercially available because the combination has been evaluated as "less than effective." Such prescriptions often result in a subtherapeutic dose of one or more of the ingredients. Since the program covers commercially available legend drugs, the proposed coverage restrictions will mainly affect orders for extemporaneously compounded products ordered to allow coverage of over-the-counter products, excessive or insufficient therapeutic doses, or contraindicated combinations.

After considerable deliberation, the committee recommended that extemporaneously compounded prescriptions continue to be covered by DHMH but that over prescribers

of compounded prescriptions be identified and counseled. The committee also agreed to address the issue of extemporaneously compounded prescriptions in the next edition of *EQUAL=TIME*. *EQUAL=TIME, Prescribing with the WHOLE Story* is a therapeutic drug use newsletter produced by the committee and the University of Maryland School of Pharmacy for distribution to physicians providing care for Medicaid patients.

The committee looks forward to continuing to address important issues surrounding prescribing practices through its newsletter, *EQUAL=TIME*. Future newsletter topics may be devoted to vitamins in adults, tranquilizers, antihypertensive medications, and the Drug Use Review board.

Committee members

Chairperson Richard M. Susel, M.D.
Arnold Brenner, M.D.
Stanley Z. Felsenberg, M.D.
Ronald Goldner, M.D.
Bruce A. Hershfield, M.D.
Dennis Kurgansky, M.D.
John O. Meyerhoff, M.D.

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Women in Medicine Committee

Mr. President and Members of the House of Delegates:

During the 1993-1994 year, the Women in Medicine Committee worked to encourage the membership and participation of women physicians in Med Chi. Women's health issues were extensively studied.

The AMA encourages state and local medical societies to recognize September as Women in Medicine Month. The committee observed Women in Medicine Month by holding a reception on Saturday, September 11, 1993, during the semiannual meeting. The reception was informal, allowing women physicians to share concerns with their colleagues. To mark the special month, the committee hung a banner, "September is Women in Medicine Month," behind the registration desk at the semiannual meeting.

The committee provided education to the membership on women's health issues by co-sponsoring a presentation at the 1994 Med Chi annual meeting entitled "AIDS Aware-

ness and Detection: Adolescents, Women, and Young Adults." Jean Anderson, M.D., assistant professor of obstetrics and gynecology at The Johns Hopkins University School of Medicine; Robert J. Ancona, M.D., chairperson of the Immunizations and Infectious Diseases Subcommittee of the Committee on Public Health and chief of the department of pediatrics at Union Memorial Hospital; and Stanley I. Blum, M.D., chief of the division of otolaryngology at North Arundel Hospital, discussed the manifestations of undiagnosed HIV, particularly in women and young people, and the specialist's involvement in the treatment of, and most recent advances in, evaluation and treatment of HIV-positive patients and patients with AIDS.

The committee continued its tradition of a Women in Medicine luncheon at the general meeting on Thursday, May 12, 1994, immediately following the educational session on AIDS awareness. This was well attended.

In the future, the committee plans to work closely with medical students to provide information about issues facing physicians. Issues of women physicians will be studied and discussed. Anyone with problems may share them with the committee for study.

The members of the committee thank Med Chi for the opportunity to serve on this committee. Comments or suggestions for future activities are welcomed from all physicians.

The committee also wishes to thank the staff of Med Chi for their help and support, particularly Vivian Smith and Angelo Troisi.

Committee members

*Chairperson Margaret T. Snow, M.D.
Vice-chairperson Randy Sue Ellis, M.D.
Marianne Benkert, M.D.
Joyce M. Boyd, M.D.
Mary A. Duke, M.D.
Susan Ferrand, M.D.
Susan R. Guarnieri, M.D.
Mahin Shamszad, M.D.
Beverly J. Stump, M.D.
Rhodora C. Tumanon, M.D.*



PALMA E. FORMICA, M.D.,
MEMBER OF THE AMA BOARD OF
TRUSTEES, AND **MARGARET T.**
SNOW, M.D., AT THE WOMEN IN
MEDICINE RECEPTION HELD
DURING THE 1993
SEMIANNUAL MEETING.

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Committee on Young Physicians

Mr. President and Members of the House of Delegates:

During the 1993-1994 year, the Committee on Young Physicians (CYP) held ongoing discussions with Med Chi staff regarding its goals for the younger physicians of Maryland. Suggestions included mailing a general letter of introduction outlining the goals of CYP and Med Chi membership benefits to appropriately selected physicians; and possibly offering a significant reduction in membership fee(s) during the first few years of practice as a means of attracting younger physicians. These issues were debated by Med Chi Council members in February 1994. Their financial impact is being studied by the Med Chi Finance Committee.

The committee discussed the "Member-Get-Member" program and "Young Physician Community Service Award" as promulgated by the AMA. Committee members have continued to search actively for new members and/or recipients using AMA's tactics.

Lecture series initially discussed during the 1992-1993 year term (to have been sponsored by Medical Communications Network and other interested agencies) were placed on hold due to the reorganization of Med Chi. It is hoped that such lecture series addressing the interests of younger physicians, particularly practice management and development, will be available in the 1994-1995 term.

Vigorous correspondence continued throughout the year with state representatives and senators in Annapolis and Washington, DC, on issues of prime concern to organized medicine (e.g., the effect of managed care, patient advocacy, and young physician payment parity from Medicare reimbursements). This correspondence has resulted in occasional, yet consistent responses from some state and federal representatives. It is hoped that these letters will have added momentum to the collective concerns of physicians in these critical times.

The committee sponsored a presentation during the 1994 annual meeting in Hagerstown entitled "When 60 Minutes comes knocking: Media training." The seminar was received enthusiastically by the audience.

The chairperson, M. Michael Massumi, M.D., represented the committee as a delegate to AMA Young Physician Section (YPS) meetings. The issues discussed during the last AMA meeting included: need for additional primary care physicians; concurrent care and reimbursement for primary care; medical industry mergers; medical access in

rural areas; effects of telemedicine on physician availability/reimbursements; "any willing provider" legislation; and federal government funding of illegal immigrants' health care. The committee also has been following the interests of the AMA YPS in securing a seat on the AMA board of trustees.

YPC committee members appreciate the continued support of Med Chi in fostering young physician participation in organized medicine.

Committee members

Chairperson M. Michael Massumi, M.D.

Nicholas Dudas, M.D.

Ronald W. Dworkin, M.D.

Gerri L. Goodman, M.D.

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DONALD H. DEMBO, M.D., 1994-1995
Med Chi president, at the 1994
presidential banquet.

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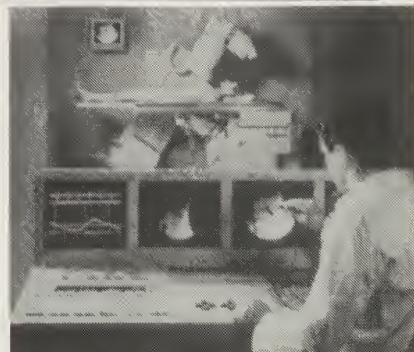
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To volunteer or for more details,
call Med Chi's Public Relations
Department at 410-539-0872
1-800-492-1056.

Doctor/Lawyer/Teacher Partnership
Against Drugs



MARC WITMAN



GRI, Associate Broker
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Preferred Properties



DREAM HOMES '94

Shelly Construction's
'Augusta.' Own one of the nine
original Dream Homes!
Designed for the large family
with 4 bedrooms, 3.5 baths.
Also features library, sun room
& second floor bonus/playroom.
Inbelievable landscaping and
appointments. \$595,000. Call
Marc about Custom Homes
starting from the mid 200's, at 828-4700.



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Historic 150+ year old home,
magnificently renovated into a
designers showplace. Only the
finest fixtures and finishes
throughout: Stuart Kitchen,
Sub-Zero, Chambers oven and
cooktop plus Jenn-air.
Corian, ceramic hardwoods
throughout. Breakfast room
with bow window affording

fabulous views of countryside! Large post and beam barn, Paddock area. Swimming Pool
too! Only \$425,000. Showing by appointment only. Call Marc at 828-4700.



Mr. President and Members of the House of Delegates:

The AMA auxiliary became an alliance as of June 1993. At the Med Chi annual meeting, May 13, 1994, we voted to change our name from auxiliary to alliance. Therefore, we will be known as the Alliance of the Medical and Chirurgical Faculty of Maryland, with the tag line "physicians' spouses dedicated to the health of America."

When I started my year as president, I wrote my goals and objectives for 1993-1994, and I am proud to say that I have been successful in reaching most of them.

My first concern was to lobby for good and reasonable health care legislation and to keep the alliance informed about what was going on in the legislative arena. At the 1993 semiannual meeting in Ocean City, we had a legislative update given by Med Chi's legislative chairperson and legal counsel. I attended a joint meeting of the alliances of Prince George's and Montgomery Counties with guest speaker Congresswoman Constance Morella of Montgomery County. I attended the AMPAC meeting in Washington in September 1993, and along with members of Med Chi visited all of our U.S. Representatives' offices. In January 1994, I was a panelist at a health care forum sponsored by Congressman Roscoe Bartlett in Frederick County. On January 26, 1994, my legislative committee planned an excellent day in Annapolis where we were able to talk to many of our delegates from the Maryland General Assembly. At a Med Chi meeting, I met with U.S. Senator Barbara A. Mikulski. Many county alliances had a legislative day in their county. On the legislative side, I feel we made a difference.

My second important goal was to fight against family violence. I donated from the philanthropic funds the money needed to buy a computer for a domestic violence shelter. The Heartly House in Frederick provides assistance to hundreds of people and I am glad the alliance could fill their real needs. At our House of Delegates meeting in October 1993, Sue Hecht, president of the Maryland Network Against Domestic Violence and director of the Heartly House, spoke to us on the problems of domestic violence. Working with the Maryland Network Against Domestic Violence, we produced a heartfelt poster urging women victims to seek help. So far, 7,000 posters have been printed and are being

placed across the state in doctors' offices, women's lounges, waiting rooms, emergency rooms, and a variety of other public and private areas. We also had Joanne Tulonen of the Maryland Alliance Against Family Violence talk to the alliance.

Increasing breast cancer awareness was my next goal. I am proud to say that many of my county alliances were able to find the funds to place billboards throughout the state to educate the public that mammography is the best defense against breast cancer.

Developing teen education programs was next on my agenda. The Wicomico County alliance helped me accomplish this. They presented their AIDS education project to the alliance board and county presidents. They have done a great job trying to educate our young people about AIDS. Their article, "Wicomico County AIDS education project," was in the January 1994 issue of *Maryland Medical Journal*. They are planning to put their program on video.

My last goal this year was to increase membership. My chairperson and alliance president-elect, Adriana Zarbin, has been working hard to promote membership and has been having membership workshops for the counties. The counties also have been working hard to increase membership, but did not do as well as we hoped.

I would like to congratulate my board and county presidents for an excellent job this year. Words cannot thank them enough for all their help and hard work. A special thank you goes to JoAnn Troisi, alliance executive director, for her help, advice, and direction.

I also would like to thank Joseph Snyder, M.D., Med Chi president; Angelo Troisi, F.A.C.H.E., chief executive officer; and Rose Matricciani, R.N., J.D., chief operating officer, for all their support, help, and assistance. A thank you also goes to Med Chi's board and staff members. Without everyone's help, it would not have been a successful year. It has been a great honor for me to serve as your 1993-1994 president.

Alliance president Georgia Chaconas Lizas

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Mr. President and Members of the House of Delegates:

It is with much pleasure that I offer this report of Med Chi members' contributions for the year 1993-1994 to the American Medical Association Education and Research Foundation (AMA-ERF).

The "flexible funds" of AMA-ERF are a boon to the deans of medical schools nationwide, for they help to offset budget deficits and restrictions. Today, federal and state funding is almost nonexistent, so it is our obligation as members of the medical family to reach out and lend a helping hand. Also, many of our needy medical students receive AMA-ERF funding through the Medical Student Assistance Fund, which affords them the opportunity to complete their medical education.

Our physicians of today, in all fields, try to cope with the ever-changing face of the profession, which is progressing at an accelerated pace. Heretofore unimaginable advances in technology and research demand extra hours of intense study and additional education. If our children and grandchildren aspire to follow in familial footsteps, there must be an avenue of financial aid available should the need arise. The message is strong and clear: we must keep AMA-ERF alive and well.

I would like to offer my heartfelt gratitude to each and all of those Med Chi members who have so generously supported our priority program—AMA-ERF. Please accept my sincere thanks for the great privilege of serving Med Chi in the role of AMA-ERF chairperson for 1993-1994.

**Med Chi contributions
June 1, 1993 – April 30, 1993**

| | |
|------------------------|-------------|
| Allegany County | \$ 600.00 |
| Anne Arundel County | 1,620.00 |
| Baltimore City | 4,440.00 |
| Baltimore County | 3,240.00 |
| Calvert County | 140.00 |
| Carroll County | 340.00 |
| Cecil County | 100.00 |
| Charles County | 200.00 |
| Dorchester County | 60.00 |
| Frederick County | 360.00 |
| Garrett County | 40.00 |
| Harford County | 900.00 |
| Howard County | 700.00 |
| Kent County | 80.00 |
| Montgomery County | 4,200.00 |
| Prince George's County | 2,680.00 |
| St. Mary's County | 80.00 |
| Talbot County | 580.00 |
| Washington County | 500.00 |
| Wicomico County | 1,100.00 |
| Total | \$21,960.00 |

**Maryland physicians' direct contributions
1993-1994**

\$8,750.00

Chairperson Elizabeth A. Linhardt



Chief Executive Officer

Mr. President and Members of the House of Delegates:

1993-1994 was a year for change: change in the national health system climate, change in the state health system climate, and change within our own organization. This report highlights the past year's activities.

1994 Legislative session

Med Chi was proud of the legislative team representing the physicians of Maryland in Annapolis. Confronting not only the winds of health system reform, the team worked diligently on all issues presented to the general assembly threatening the practice of medicine. Med Chi continued to keep members informed of Maryland's legislative activities through both the *Legislative Action* newsletter (which provides synopses of bills, the Med Chi Legislative Committee's action on each bill, and a calendar of upcoming hearings) and the toll-free hotline. In place of the traditional legislative rally, Med Chi physicians gathered for "Doctors' Day" in Annapolis on February 17, 1994, in an effort to increase the communication between the medical community and Maryland's legislative representatives. The day began with a short legislative briefing by Hilary T. O'Herlihy, M.D., Legislative Committee chairperson, and Med Chi lobbyist Jay Schwartz, Esq. After the briefing, physicians met by appointment with legislators to discuss their mutual interest in the quality of care for Maryland's citizens. (For a detailed

account of the 1994 legislative session, see the Legislative Committee report.)

In addition to its statewide efforts, Med Chi also supported federal initiatives promulgated by the AMA, such as the Patient Protection Act and antitrust reform.

Information hotline

This year Med Chi installed a new 800-number hotline to provide members with up-to-date information on state and federal legislative issues, various topics of importance, and information on Med Chi events. The hotline, which allows physicians to call at their convenience, day or night, and receive the most current information available, has been well received and well used; almost 600 calls have come into the system during the past six months, totaling more than 1,660 minutes of usage by members.

New bylaws

A retreat committee was established and met for the first time in November 1993 to review the organizational structure and mission of Med Chi. Under the guidance of professional facilitators, the retreat committee drafted new bylaws for the organization. After much work, the bylaws as recommended by the Retreat Committee and reviewed by the Bylaws Committee, were presented to the Med Chi



Elizabeth A. Linhardt, Maryland AMA-ERF chairperson, presents a check for medical student funding to Ms. Ruth Bulger, vice president of the Henry M. Jackson Foundation, for the Uniformed Services University of the Health Sciences.

House of Delegates and accepted in May 1994. The most significant changes were the dissolution of the Med Chi Council and the creation of a 19-member board of trustees and eight new councils. Also, the Med Chi House of Delegates will now meet quarterly instead of biannually.

1993 AMA annual meeting

On June 16, 1993, during the AMA annual meeting, Donald "Ted" Lewers, M.D., past president of Med Chi, became the first Eastern Shore physician to be elected to the AMA Board of Trustees. The Maryland delegation to the AMA campaigned for Dr. Lewers throughout the meeting.

Also, at the AMA annual meeting, the Maryland delegation was pleased to coordinate the presentation of Ryohei Kawaguchi, M.D., president of the Kanagawa Prefectural Medical Association (Maryland's sister state medical association in Japan), before the Organization of State Medical Association Presidents and Executives. Much appreciation to Med Chi's Hiroshi Nakazawa, M.D., who acted as moderator and interpreter.



ROBERT MCAFEE, M.D., 1994-1995
AMA PRESIDENT, ADDRESSES THE HOUSE OF
DELEGATES MEETING DURING THE 1994
ANNUAL MEETING.

Hosting Russian delegation

Med Chi had the pleasure of hosting the Medical Personnel Delegation from Russia in June 1993. The delegation comprised 19 Russian citizens and included physicians, dentists, nurses, health administrators, and government officials. The group received a tour of the Med Chi building and discussed medical insurance, malpractice, the cost of health care services, and the medical community's role in the legislative process.

Maryland Physicians Campaign Against Family Violence

In September 1993, Med Chi announced the initiation of the Maryland Physicians Campaign Against Family Violence. The campaign, designed to educate health care providers about the prevalence of family violence, its impact on the health of its victims, and the need for intervention by the medical community, was developed with the Maryland Alliance Against Family Violence. The campaign theme selected was "Unlock The Silence. Trust Is The Key." The first area to be targeted was domestic violence, also known as partner abuse. The next two areas to be addressed will be child abuse and elder abuse. For more information about the campaign, see the Family Violence Task Force report.

Statewide substance abuse program

"Substance Abuse Education for the Primary Care Physician," originally offered in Baltimore City locations only, expanded to a statewide substance abuse education program in October 1993. The program focuses on screening, counseling, and referring substance abusing-patients.

Annual meeting

The 196th Annual Meeting of the Medical and Chirurgical Faculty of Maryland, "Medicine Under Health System Reform—Impact on Patients and Physicians," was held May 12-14, 1994, at the Ramada Inn and Convention Center in Hagerstown, Maryland. Med Chi's first semiannual meeting was held in Hagerstown in 1889. Also of interest, Med Chi was last in Hagerstown for a semiannual meeting in September 1954—40 years ago. AMA president-elect Robert E. McAfee, M.D., provided the keynote address. Maryland physicians were given the opportunity to earn CME credits on such topics as AIDS, benign prostatic hyperplasia, tuberculosis, as well as a variety of health system reform topics.

Semiannual meeting

The semiannual meeting was held September 10-12, 1993, at the Sheraton Ocean City Resort and Conference

Center. AMA trustee Palma E. Formica, M.D., provided the keynote address. A plenary session on "Health System Reform: The Effect on Patient Care" was held and panel members included the Honorable Gary R. Alexander, speaker pro tem of the Maryland House of Delegates; Alex Azar, M.D., commissioner of the Health Care Access and Cost Commission; John Colmers, executive director of the Health Care Access and Cost Commission; Palma E. Formica, M.D.; Robert Pulliam, M.D., immediate past president of the West Virginia Medical Association and member of the West Virginia House of Delegates; and Joseph Snyder, M.D., Med Chi president.

Special conferences

In an effort to keep Med Chi informed of issues affecting physicians throughout the state and to keep members informed of Med Chi activities, the tradition of the president's regional conferences was continued. An eastern regional conference was held October 19, 1993, in Cambridge, Maryland; a western regional conference was held November 11, 1993, in Hagerstown, Maryland; and a southern regional conference was held April 7, 1994, in Solomons, Maryland. Physicians attending the meetings were briefed on efforts in the legislative arena as well as current Med Chi programs and events. In addition, the meetings provided

opportunities to obtain continuing medical education (CME) credits. Western Maryland physicians were offered "Pearls of Rheumatology"; Southern Maryland physicians were offered "Standards for Identifying and Treating Common Infectious Diseases"; and Eastern Maryland physicians heard "Anxiety Versus Depression: Identification and Treatment." Each provided one CME credit.

On December 11, 1993, the Physician Rehabilitation Committee held its fourth annual conference on addiction. Topics included the biomedical aspects of addiction, nicotine addiction, the nature and present status of drug abuse treatment, the need for greater access to treatment, the future of drug control policy in America, helping the helpers, and use and abuse of heroin and other opioids. Held at the Sheraton International Hotel at BWI Airport, the conference attracted physician members as well as a number of physician nonmembers and allied health professionals.

On behalf of the staff of Med Chi, I would like to thank all Med Chi members for their contributions during the 1993-1994 year. We look forward to working with you again in the new year.

Chief Executive Officer Angelo J. Troisi, F.A.C.H.E.

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The Maryland Medical Political Action Committee

Mr. President and Members of the House of Delegates:

The Maryland Medical Political Action Committee (MMPAC) met six times during the 1993-1994 term. Those named below are serving a two-year term that will end in the spring of 1995. Angelo J. Troisi, F.A.C.H.E., chief executive officer, continues to serve as the advisor to the MMPAC executive committee and the MMPAC board of directors. The MMPAC board of directors has a broad representation of all the Med Chi component societies.

The purpose of the MMPAC, as stated in its bylaws, is to encourage its members to understand the nature and actions of their government; to inform them of important legislation and political issues affecting the medical profession; to present to its members the record of office holders and candidates for elective office; to assist its members in organizing themselves for effective political activity and civic responsibility; and to lend support to and work for the

nomination and election of any candidate for public office representing the best interests of the public and medicine's viewpoint.

To this end, every physician should be aware of the legislative process at the state and federal levels. During this election year (1994), the MMPAC will be supporting candidates whose political views support the medical profession. Although MMPAC membership increased 10% in 1993, overall membership has decreased 35% over the past four years.

With changes in the health care delivery system, non-medical forces are impinging on physicians' ability to make the choices that are right for their patients. MMPAC needs the help of every physician who cares about preserving quality of health care to join us today. Protect the special relationship between you and your patients; join the Mary-

land Medical Political Action Committee so that we can continue to educate the community and interact with the legislative system in providing the best possible health care.

MMPAC executive committee

Chairperson Frederick J. Hatem, M.D.

Vice-chairperson Hilary T. O'Herlihy, M.D.

Secretary Hiroshi Nakazawa, M.D.

Treasurer Jose M. Yosucio, M.D.

Assistant treasurer Thomas E. Allen, M.D.

MMPAC board of directors

Brian Bayly, M.D.

Marianne Benkert, M.D.

Richard Bernstein, M.D.

Emidio Bianco, M.D.

Bayani Elma, M.D.

Michael Epstein, M.D.

J. Ramsay Farah, M.D.

Catherine Hazelnus-Smoot, M.D.

F. Japzon, M.D.

Arnold Levy, M.D.

Donald Ted Lewers, M.D.

Mayer C. Liebman, M.D.

J. Richard Lilly, M.D.

George Malouf, M.D.

J. David Nagel, M.D.

Gary Rosenberg, M.D.

Ellie Sayan, M.D.

Howard Silby, M.D.

Roland Smoot, M.D.

Margaret Snow, M.D.

Joseph Snyder, M.D.

Mrs. Bessie Blaire, Alliance

Mrs. Myrna Goodman, Alliance

Mrs. Georgia Lizas, Alliance

Mrs. Lea Prichep, Alliance

Mrs. Sue Sherwood, Alliance

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Med Chi Insurance Fund

Mr. President and Members of the House of Delegates:

The Med Chi Insurance Fund Committee and Board of Directors met five times during 1993 to carry out their responsibilities for the Med Chi Insurance Fund and Med Chi Agency. The Med Chi Agency continued its new business growth and expanded its staff to accommodate additional opportunities in all sectors of the operation. All lines of insurance are currently offered and available to members, including estate and financial planning services.

The board approved a minimal increase of 9.8% for the association group health plan options with BlueCross BlueShield effective September 1, 1993. The Med Chi Agency also offers alternative health plans for members who elect not to participate in the BlueCross BlueShield Association group plans.

The board reviewed the appropriate financial statements and claim report statistics with company representatives. As a result of this review, the board approved a 20% premium increase for the Hartford major medical plan.

The client base of the Med Chi Agency increased in property and casualty and in professional liability with the

Medical Mutual Liability Insurance Society of Maryland (Med Mutual). Commission income was down in 1993 due to special discounts and tail buy-backs offered to Med Mutual policyholders.

The Med Chi Agency had a very successful year and membership has benefited as a result. The board appreciates members' ongoing support and will strive diligently to offer the highest quality, financially stable, and competitively priced products and services for Med Chi members.

Committee members

Chairperson Allan D. Jensen, M.D.

Carol Garvey, M.D.

Michael R. Dobridge, M.D.

Allan T. Leffler, M.D.

George S. Malouf, Sr., M.D.

Francis C. Mayle, Jr., M.D.

Joseph Snyder, M.D.

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Treasurer

Mr. President and Members of the House of Delegates:

The financial statements of Med Chi as of December 31, 1992, were audited by the independent certified public accounting firm of Naden/Lean. I am pleased to report that Med Chi again has received an unqualified opinion (the highest opinion that can be expressed by any CPA firm) on its financial statements. The complete audit report for the members was published in the September 1993 issue of the *Maryland Medical Journal*. The December 31, 1993, audit will start shortly (some preliminary work already has begun).

Med Chi also was audited by the Maryland state legislative auditors in the areas of physician rehabilitation and peer review. These were performance audits that covered the three-year period from August 1, 1990, to July 31, 1993. It took the state auditors over 300 man days of field work to complete the project. After such an exhaustive testing and verification process, the auditors' findings were minor in nature. All comments were promptly addressed in writing to various state officials. Governor William Donald Schaefer issued a letter of thanks to Med Chi for sending him a copy of the legislative auditors' report and he suggested that it appeared that the auditors overstepped their bounds.

During the current year, we purchased a new telephone system and set up a new "800" information line that allows members access to eight different topics on a daily basis. We recently contracted for the networking of all Med Chi computers and purchased new accounting, membership, and convention software that will increase efficiency.

In 1993, Med Chi spent considerable time getting its books in order. Now, with better financial data, we can project that an increase in the 1994 membership dues is warranted just to maintain the current services. Med Chi membership dues remain the lowest in the continental United States; the last dues increase occurred in 1979. The amount of the proposed dues increase will be addressed at the semiannual meeting (September 1994) in Ocean City, Maryland.

Treasurer Carol W. Garvey, M.D.

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MICHAEL A. WILLIAMS, M.D., ACCEPTS A CERTIFICATE OF RECOGNITION FOR HIS ELECTION TO THE AMA COUNCIL ON SCIENTIFIC AFFAIRS FROM GEORGE S. MALOUF, SR., M.D., CHAIRPERSON, MARYLAND DELEGATION TO THE AMA.

1994 BUDGET

DEPARTMENT EXPENSES

| | Administration | Finance & Membership | Maintenance & Janitorial | MMJ | P.R., Graphics & Conventions | Peer Review |
|-----------------------------|----------------|-------------------------|-----------------------------|-----------|---------------------------------|----------------|
| Salary | \$280,050 | \$164,223 | \$81,349 | \$48,111 | \$112,141 | \$158,602 |
| Salary incentive | | | | | | |
| Benefits | 70,013 | 39,432 | 22,778 | 11,954 | 28,036 | 38,064 |
| Supplies | 5,500 | 1,200 | 11,000 | 500 | 5,000 | 3,000 |
| Equipment | | | | | | 2,500 |
| Maintenance | | | | | | 200 |
| Software | | 13,700 | | | | |
| Travel | 15,000 | 800 | 800 | 150 | 1,300 | 500 |
| Education courses | 3,000 | 500 | | 1,000 | 2,150 | 4,000 |
| Membership & certification | 2,500 | 500 | | 100 | 300 | 250 |
| Publications | 4,000 | 100 | | 120 | 900 | 200 |
| Postage and shipping | 15,000 | 6,500 | | 28,000 | 8,200 | 5,500 |
| Printing and publishing | | 3,000 | | 181,500 | 15,000 | 25,000 |
| Photocopying | | | | | | 7,000 |
| Contract services | | | 27,000 | 14,904 | 16,904 | |
| Meetings | 28,000 | | | | | 3,600 |
| AMA delegation travel | 82,232 | | | | | |
| AMA OSMAP | 300 | | | | | |
| AMA candidate support | 25,000 | | | | | |
| AMA S.E. delegation | 3,500 | | | | | |
| AMA delegation, misc. | 2,000 | | | | | |
| Leadership conference | 5,500 | | | | | |
| President's honorarium | 30,000 | | | | | |
| President's expense account | 4,000 | | | | | |
| Data processing | | 3,000 | | | | |
| Auditing | | 11,500 | | | | |
| Awards | | | | 225 | 4,000 | |
| Photo supplies | | | | | 2,200 | |
| Gifts and memorials | | | | | 850 | |
| Interlibrary loans | | | | | | |
| Medlars | | | | | | |
| Music in medicine | | | | | | |
| Rent & indirect expense | | | | | | 13,600 |
| Auxiliary | | | | | | |
| Marketing | | | | | | |
| Annual meeting | | | | | 60,000 | |
| Semiannual meeting | | | | | 20,000 | |
| Utilities | | | | | | |
| Telephone | 3,600 | | | | | 4,800 |
| Stupak Radio Program | | | | | | |
| Insurance | | | | | | |
| Parking | | | | | | 3,900 |
| Handbook | | | | | 3,800 | |
| Bylaws | | | | | 3,000 | |
| Directory | | | | | 20,000 | |
| Lobbyists & expense | | | | | | |
| Direct family violence | | | | | | |
| First aid supply room R.N. | | | | | | |
| Annapolis office | | | | | | |
| Miscellaneous | | 1,500 | | | | |
| Contingency fund | 50,000 | | | | | |
| TOTAL | \$629,195 | \$245,955 | \$142,927 | \$286,564 | \$303,781 | \$270,716 |

1994 BUDGET DEPARTMENT EXPENSES

| Human Resources | Legal & Govt. Relations | Computer Services | Library | Education | Physicians Rehab | Corporate | TOTAL |
|-----------------|-------------------------|-------------------|-----------|-----------|------------------|-----------|-------------|
| \$66,547 | \$149,150 | \$55,650 | \$132,869 | \$154,763 | \$175,217 | \$25,656 | \$1,604,328 |
| | | | | | | 20,000 | 20,000 |
| 15,949 | 35,000 | 15,582 | 30,560 | 37,143 | 42,052 | 4,914 | 391,477 |
| 150 | 3,000 | 3,500 | 4,000 | 5,000 | 5,000 | 25,000 | 71,850 |
| | | 30,000 | | | 3,000 | 24,500 | 60,000 |
| | | 10,000 | | | 2,700 | 40,000 | 52,900 |
| | | | | | | | 13,700 |
| 100 | 4,000 | 500 | 2,500 | 5,000 | 5,000 | | 35,650 |
| 500 | 1,000 | 1,500 | 1,500 | | 31,000 | | 46,150 |
| 300 | 2,000 | 200 | 800 | 8,091 | 23,000 | | 38,041 |
| 1,300 | 3,200 | 500 | 200 | | 1,500 | | 12,020 |
| 250 | 22,000 | 500 | 3,800 | 5,000 | 15,800 | 20,000 | 130,550 |
| | | 50 | 1,500 | 1,500 | 23,000 | | 250,550 |
| | | | 500 | | 2,500 | 30,000 | 40,000 |
| 1,500 | | 3,000 | 3,000 | 9,000 | 2,800 | | 78,108 |
| | 13,000 | | | | 1,200 | | 45,800 |
| | | | | | | | 82,232 |
| | | | | | | | 300 |
| | | | | | | | 25,000 |
| | | | | | | | 3,500 |
| | | | | | | | 2,000 |
| | | | | | | | 5,500 |
| | | | | | | | 30,000 |
| | | | | | | | 4,000 |
| | | | | | | | 3,000 |
| | | | | | 1,200 | | 12,700 |
| | | | | | | | 4,225 |
| | | | | | | | 2,200 |
| 1,500 | | | | | | | 2,350 |
| | | | 4,000 | | | | 4,000 |
| | | | 3,000 | | | | 3,000 |
| | | | 1,000 | | | | 1,000 |
| | | | | | 27,000 | | 40,600 |
| | | | | | | 1,000 | 1,000 |
| | | | | 2,000 | 10,000 | | 12,000 |
| | | | | | | | 60,000 |
| | | | | | | | 20,000 |
| | | | | | | 78,000 | 78,000 |
| | 3,000 | | | | 4,000 | 45,000 | 60,400 |
| | | | | | | 20,000 | 20,000 |
| | | | | | | 50,000 | 50,000 |
| | | | | | 3,000 | 15,000 | 21,900 |
| | | | | | | | 3,800 |
| | | | | | | | 3,000 |
| | | | | | | | 20,000 |
| | 162,800 | | | | | | 162,800 |
| | | | | 25,000 | | | 25,000 |
| | 8,000 | | | | | | 8,000 |
| | 27,000 | | | | | | 27,000 |
| | | | | | 2,200 | 2,000 | 5,700 |
| | | | | | | | 50,000 |
| \$88,096 | \$433,150 | \$120,982 | \$189,229 | \$252,497 | \$381,169 | \$401,070 | \$3,745,331 |

1994 BUDGET

DEPARTMENT REVENUES

| | | | | | |
|---|--------------------|--|--|--------------------|--|
| Library | | | Finance and membership | | |
| ICD9 code books | 500 | | Membership dues | \$1,155,000 | |
| Hospital library cataloging | 500 | | Short-term investments | 450,000 | |
| Hospital library periodicals | 350 | | Interest income | 175,000 | |
| Interlibrary loans | 10,500 | | Investments--other funds | 212,000 | |
| Literature searches | 7,000 | | Insurance activities | 174,000 | |
| Music in medicine | 200 | | Rental income | 64,200 | |
| Nonaffiliated user registration | 5,000 | | Collection service | 28,150 | |
| Salary and benefits paid | 65,736 | | Credit cards | 1,500 | |
| Physician book orders | 100 | | Parking | 800 | |
| Hospital book orders | 600 | | Lists and labels | 9,000 | |
| TOTAL | \$90,486 | | Subscription services | 200 | |
| Computer services | | | Dues collection fees | 5,000 | |
| AMA profile | \$300 | | Specialist identification | 3,000 | |
| Education | | | Associated (ACEP\MSEPS) | 12,000 | |
| Statewide Substance Abuse grant | 60,000 | | TOTAL | \$2,289,850 | |
| Diabetes grant | 22,000 | | Maryland Medical Journal | | |
| Continuing medical education | 4,000 | | Local advertising | 139,680 | |
| Med-Lantic Management grant | 139,000 | | National advertising | 19,200 | |
| Patient\Physician Reminder System grant | 22,800 | | Classified advertising | 9,300 | |
| Family Violence initiative - from Cordel Fund | 25,000 | | Reprints | 5,000 | |
| TOTAL | \$272,800 | | Subscriptions | 7,000 | |
| Corporate/Undistributed | | | Non-subscription sales | 1,200 | |
| Stupak radio program | 20,000 | | Miscellaneous | 100 | |
| Building fund | 30,000 | | TOTAL | \$181,480 | |
| TOTAL | \$50,000 | | Graphics | | |
| Administraion | | | Directory sales | 9,000 | |
| Healthy Start revenue | \$12,000 | | Directory advertising | 25,000 | |
| Physicians Rehab | | | <i>The Maryland Psychiatrist</i> | 600 | |
| Licensure accessment | 500,000 | | <i>Physician's Practice Digest</i> | 5,000 | |
| Investment income | 10,000 | | Compendium | 300 | |
| Conference revenue | 10,000 | | <i>Model Hospital Medical Staff Bylaws</i> | 300 | |
| Focused professional education | 13,000 | | TOTAL | \$40,200 | |
| Unbilled BPQA income | 65,000 | | Public relations and conventions | | |
| TOTAL | \$598,000 | | Annual meeting exhibits | 20,000 | |
| TOTAL REVENUES | \$3,579,916 | | Semiannual meeting exhibits | 15,800 | |
| TOTAL EXPENSES | \$3,745,331 | | Travel revenue | 1,500 | |
| | | | Annual meeting ticket sales | 7,500 | |
| | | | TOTAL | \$44,800 | |

The Baltimore Healthy Start Fetal and Infant Mortality Review

Mr. President and Members of the House of Delegates:

Infant mortality in Baltimore City has been a persistent public health problem. At 16.6 per thousand live births, Baltimore has one of the highest rates in the nation. The Baltimore City Healthy Start program is attempting to reduce infant mortality in two areas of the city with the highest fetal and infant death rates (over 20 per 1,000). This multifaceted program is at the midpoint of a five-year, federally funded grant. Baltimore Healthy Start has contracted with Med Chi to operate a fetal and infant mortality review (FIMR) as one component of this major effort to reduce infant mortality by 50% in Baltimore City.

The purpose of the FIMR is to learn from the deaths that do occur in order to prevent them in the future. FIMR is a process that organizes a community for improved services to women and infants. Not an hypothesis-testing study or a quality assurance check, the review is a qualitative look at at-risk patients and their interaction with the system of care. Med Chi staff perform case reviews of fetal and infant death by interviewing the family and abstracting the medical records. The de-identified cases are then presented to a multidisciplinary review board. The board reviews the cases for factors that could be improved by system changes, then makes policy recommendations to the health care and

human service providers in Baltimore. Recommendations and reports will be made to the Healthy Start Consortium, which is composed of all relevant city providers and agencies. The FIMR process is being instituted in many communities in the nation, although this is the first to begin operation in Maryland.

The Baltimore Healthy Start Fetal and Infant Mortality Review is staffed by Rose Matricciani, R.N., J.D.; Daniel Timmel, L.C.S.W., project coordinator; and Evonne Stepney, interviewer, with contract assistance from Joan Jensen, R.N. Harold Elberfeld, M.D., chairperson of the Maternal Welfare Subcommittee, also chairs the multidisciplinary review board, and the subcommittee will be reviewing medical abstracts for the project. The project draws on clinical experience by direct providers and academic expertise from the University of Maryland at Baltimore and The Johns Hopkins School of Hygiene and Public Health. Hospitals and other health care providers in the city are working with the FIMR project to identify cases, access records, and eventually implement recommendations. Call Dan Timmel at Med Chi for further information.

□ □ □

Maryland Diabetes Control Program Demonstration Project

Mr. President and Members of the House of Delegates:

In conjunction with the Maryland Diabetes Control Program, Med Chi developed a diabetes handbook for use by primary care physicians and their patients with diabetes. It was designed to help patients maintain better control of their diabetes by taking more responsibility for their health care and to remind physicians of the recommended preventive services to be performed at each patient visit. The handbook follows the recommendations of the Centers for Disease Control and Prevention. It was developed after a thorough

literature review and focus groups conducted throughout Maryland. It has been field tested in various primary care settings.

In addition to the handbook, Med Chi also developed an education program to teach physicians how to use the handbook with their patients and will be presenting this program during the 1994 semiannual meeting.

□ □ □

Substance Abuse Education Program

Mr. President and Members of the House of Delegates:

In 1991, Med Chi received a grant from Baltimore Substance Abuse Systems, Inc., to develop and implement an educational program for primary care physicians in Baltimore on the subject of alcohol and other drug abuse. The objective of the program was to improve the ability of physicians to identify, treat, and refer their substance abusing patients.

Two curricula were developed. One provided a general overview on topics such as the scope of the drug abuse problem, screening and assessment procedures, and treatment programs. The other addressed opioid abuse. After two years of implementation of the project in Baltimore City, the Governor's Drug and Alcohol Abuse Commission gave Med Chi a grant to expand the project to primary care physicians throughout Maryland. The program is currently

being offered and presented to physicians in every county in the state.

To date, the program has reached over 1,000 health care providers, with over 90% of participants stating that they would recommend the program to their colleagues. In addition to the presentations of the program in the community, a self-study guide was developed to make the course even more accessible to the busy practicing physician. The self-study guide has been made available to every primary care physician in Maryland. To further expand the substance abuse education program, Med Chi is applying for a grant that would be used to develop and present a curriculum that provides in-depth information on screening and assessing patients for substance abuse.

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Med Chi Bicentennial Celebrations

*Med Chi has already begun planning celebration activities for its bicentennial in 1999.
If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at
410-539-0872 or 1-800-492-1056.*

In Memoriam

James G. Arnold Jr., M.D., founder of the neurosurgery division at the University of Maryland School of Medicine and a faculty member there for 56 years, died of cancer May 8, 1994, in Highlands, North Carolina. A native of Atlanta, Dr. Arnold received his medical degree from The Johns Hopkins University School of Medicine in 1929. He served a residency in tuberculosis at the old Baltimore City Hospital before coming to the University of Maryland medical school in 1932, where he served as a Hitchcock Fellow for three years. He completed his training in neurological surgery in 1944. A pioneer in the chemotherapy of infectious diseases, Dr. Arnold was an authority on spinal surgery. Upon his retirement in 1976, he was appointed professor of neurosurgery emeritus and in recognition of his many achievements, the division of neurosurgery named its library after him. A 40-year member of Med Chi, Dr. Arnold was a member of the American Medical Association, Harvey Cushing Society, Society of Neurological Surgeons, Johns Hopkins Medical and Surgical Association, and Southern Surgical Association. He was 89.

Katherine H. Borkovich, M.D., an internist, cardiologist, and educator, died of a heart attack at her home in Baltimore, June 4, 1994. She earned her undergraduate degree at Geneva College in Beaver Falls, Pennsylvania, and was a 1939 graduate of The Johns Hopkins School of Medicine, where she later taught. She retired from teaching in 1991, but maintained her private practice until her death. Respected for her accomplishments, Dr. Borkovich was the first woman elected president of the Baltimore City Medical Society. In addition, she was president of the Maryland Society of Internal Medicine in 1964, and in June 1993, she was inducted into the Johns Hopkins Women's Medical Alumnae Association of Fame. Dr. Borkovich was 78.

Abraham W. Danish, M.D., a retired internist and gastroenterologist who had practiced in Silver Spring for 42 years, died of cancer at his home there, June 19, 1994. Born in Philadelphia, Dr. Danish received his medical degree from George Washington University, where he was an adjunct professor from 1956 to 1988. He was chief of medicine at Washington Adventist Hospital and later at Holy Cross Hospital, where he also was chief of gastroenterology. Named clinician of the year by the Montgomery County Medical Society in

1982, he was a past president of the Community Psychiatric Clinic and the Montgomery County chapter of the American Cancer Society. He became president of the Maryland College of Art and Design in Silver Spring following his retirement from medicine in 1992. Dr. Danish, a 40-year member of Med Chi, was 77.

Julius Loebel, M.D., died May 3, 1994, in Little Rock, Arkansas, following a long illness. Originally from Hamburg, Germany, Dr. Loebel received his medical degree in Bern, Switzerland. He practiced pediatric medicine from 1946 until 1967, when he became director of maternal and child health for the Anne Arundel County Health Department, a position he held until his retirement in 1981. A long-time resident of Baltimore, he is survived by his wife, Berniece, two sons, Edward and Richard, and four grandchildren.

Deonis M. Lupo, M.D., a 40-year Med Chi member and Baltimore surgeon and gynecologist, died at his home, March 30, 1993, of cancer. Originally from Stamford, Connecticut, Dr. Lupo earned his medical degree at Jefferson Medical College in Philadelphia. He served as an intern at City Hospital (now the Francis Scott Key Medical Center) until 1933, when he became chief resident in medicine at South Baltimore General Hospital (now Harbor Hospital Center). In 1934, he was assigned to the traumatic surgery department at Walter Reed Army Hospital in Washington, DC, and in 1936, returned to South General as chief surgical resident. He entered private practice in 1938. Harbor Hospital Center plans to name a new inpatient cancer center for Dr. Lupo and his late wife, Betty. Dr. Lupo was 88.

John T. Lynn, M.D., an orthopedic surgeon and former president of the Prince George's County Medical Society, died June 7, 1994. Dr. Lynn received his medical degree from Jefferson Medical College and then served in the United States Army. After practicing general medicine for four years, he returned to Jefferson Medical College for his residency in orthopedic surgery. In addition to his devoted service to his patients and community, Dr. Lynn served as president of the Washington Orthopaedic Society from 1976 to 1977, treasurer of the Prince George's County Medical Society Charitable Foundation for over a decade, and chairperson of the Maryland Medical Political Action Committee from 1991 to 1993.

Gibson J. Wells, M.D., a retired pediatrician, died of cancer at his home in Ruxton, May 23, 1994. Born in Baltimore, Dr. Wells was a 1932 graduate of The Johns Hopkins University and a 1936 graduate of the University of Maryland School of Medicine. In 1940, he started his medical practice in Baltimore and worked as a draft board examiner and a pediatric consultant to Provident Hospital. Dr. Wells put his private practice on hold when he became a medical officer and an acting chaplain aboard the U.S.S. Casa Grande in the Philippines and Okinawa during World War II. Returning to his practice in 1946, he also became an associate professor in pediatrics at the University of Maryland School of Medicine and chief of pediatrics at Maryland General and Lutheran hospitals. Certified by the American Board of Pediatrics, Dr. Wells was a staff member of many hospitals in the Baltimore area and former chairperson of the pediatric section for the Baltimore City Medical Society. After retiring, he devoted his time to his other roles as registrar, historian, and vestryman at St. Michael and All Angels Episcopal Church. He was ordained a deacon in 1974 and often gave Holy Communion to those who could not attend church. Dr. Wells was 82.

No additional information was available at press time for the following members:

Bernard Burgin, M.D.

Baltimore City, April 23, 1994

John Cosmo, M.D.

Prince George's County, May 17, 1994

Abram Goldman, M.D.

Baltimore City, May 1, 1994

Herbert Insel, M.D.

Prince George's County, May 13, 1994 ■

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MEDICAL POLICY

SUBJECT: COLONY STIMULATING FACTORS (CSF)

EFFECTIVE DATE: Retroactive to 2/21/91

1. NEUPOGEN (FILGRASTIM)

CPT/HCPCS Code(s): J9999 prior to 7/1/92
Q0093 for dates of service on and after 7/1/92
J1440 (300 mcg) and
J1441 (480 mcg) for dates of service on and after 1/1/94.

2. LEUKINE AND PROKINE (SARGRAMOSTIM)

CPT/HCPCS Code(s): J9999 prior to 7/1/92
Q0094 for dates of service on and after 7/1/92 through 12/31/93
J2820 (250 mcg) for dates of service on and after 1/1/94

Description of Service:

NEUPOGEN, LEUKINE and PROKINE are human granulocyte colony stimulating factors produced by recombinant DNA technology. These growth factors stimulate proliferation and differentiation of neutrophils. They have been shown to be safe and effective in accelerating the recovery of neutrophil counts following a variety of chemotherapy regimens and for patients undergoing bone marrow transplantation.

NEUPOGEN, LEUKINE and PROKINE can be given by either subcutaneous or intravenous injection. The dosage is calculated in micrograms per kilogram (kg.) of body weight.

Clinical Indications:

COLONY STIMULATING FACTORS are approved by the FDA for use in patients with non-myeloid malignancies who are receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia and fever.

When performed on patients with non-myeloid malignancies who are receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever and on patients who are undergoing bone marrow transplant, the subcutaneous and intravenous administration of NEUPOGEN, LEUKINE and PROKINE is a covered service. The self-administration of COLONY STIMULATING FACTORS is non-covered under the Medicare program

NOTE: Payment may be made for COLONY STIMULATING FACTORS under Medicare’s “incident to” provision. For the “incident to” a physician’s service provisions to be met, (1) the cost of COLONY STIMULATING FACTORS must represent an expense to the physician who administers it, (2) it must be administered by the physician or by someone in the physician’s direct employ and (3) if administered by someone in the physician’s employ, it must be administered under the physician’s direct, personal supervision.

A complete blood count (CBC) and platelet count should be obtained as a baseline and usually twice per week during COLONY STIMULATING FACTOR therapy to avoid leukocytosis and to monitor the neutrophil count.

Claims for the COLONY STIMULATING FACTORS must indicate (a) the diagnosis of the malignancy and the name(s) of the anti-cancer drug(s) the patient is receiving, or (b) the diagnosis code for which the bone marrow transplantation is being performed.

EMC CLAIMS: This information should be placed in the narrative or free form comment field in the patient management software.

PAPER CLAIMS: This should be shown in Section 24D of the claim form where it states “Explain Unusual Circumstances.”

ICD-9-CM Code(s):

NON-MYELOID MALIGNANCIES:

| | |
|-----------------|-----------------|
| 140.0 - 149.9 | Head and Neck |
| 160.0 - 162.0 | |
| 190.0 - 193.0 | |
| 195.0 | |
| 200.00 - 202.88 | Lymph and Blood |
| 179.0 - 189.9 | GU |
| 198.0 - 198.1 | |
| 198.6, 198.82 | |
| 162.2 - 165.9 | Lung and Chest |
| 195.1 | |
| 197.0 - 197.3 | |
| 174.0 - 175.9 | Breast |
| 198.81 | |
| 150.0 - 159.9 | GI |
| 195.2 - 195.3 | |
| 197.4 - 197.8 | |

170.0 - 173.9
176.0 - 176.9
194.0 - 194.9
195.4 - 195.8
196.0 - 196.9
198.2, 198.5
198.89
199.0 - 199.1

Other

288.0

Neutropenia (chemotherapy - induced) associated with bone marrow transplantation.

NEUPOGEN is billed in units of 300 mcg (J1440) or 480 mcg (J1441.) Providers should indicate in item 24G of the claim form the number of units administered to the patient. For EMC claims, this should be shown in field 18 of the FAO record.

LEUKINE AND PROKINE are billed in units of 250 mcg. Providers should indicate in item 24G of the claim form the number of units administered to the patient. For EMC claims, this should be shown in field 18 of the FAO record.

Barry S. Gold M.D.

Approved by:

Barry S. Gold, M.D., F.A.C.P.
Medical Director

Provider Notifications:

Draft policy to Carrier Advisory Committee (CAC) November 1, 1993

Final policy to CAC June 29, 1994

MEDICAL POLICY**SUBJECT: UPPER GASTROINTESTINAL ENDOSCOPY****EFFECTIVE DATE: 4/20/90****REVISED DATE: 12/31/92 and 6/24/94****CPT/HCPCS Code(s): 43200 - 43272****Description of Service:**

Upper gastrointestinal (UGI) endoscopy enables direct visualization of the upper gastrointestinal tract by means of a long, flexible, fiberoptic lighted scope. Esophagogastro-duodenoscopy (EGD) is a technique in which a flexible instrument is utilized to examine the esophagus, stomach and duodenum, to obtain samples, as appropriate, and in some cases, to treat pathology.

Besides being much more sensitive and specific than an upper GI series in diagnosing diseases of the esophagus, stomach and duodenum, the EGD can also be used therapeutically. An experienced endoscopist can control active GI bleeding by electrocoagulation, laser coagulation, or the injection of sclerosing agents. Also, with the endoscope, benign and malignant structures can be excised and strictures can be dilated to re-establish patency of the upper GI tract. A percutaneous gastrostomy can be placed with the use of EGD.

Clinical Indications:

Endoscopic examination of the upper GI tract is indicated and covered for the following conditions:

Diagnostic Indications for UGI Endoscopy

- to establish the site of gastrointestinal bleeding, occult or overt, when an UGI source is suspected
- to visually define and biopsy abnormalities seen on UGI series (gastric ulcers, filling defects, masses, lesions, stricture, etc.)
- to follow up treated gastric ulcers
- to evaluate dysphagia, dyspepsia, abdominal pain and emesis

Therapeutic Indications for UGI Endoscopy

- for removal of foreign bodies of esophagus, stomach or duodenum
- for removal of polyps of esophagus, stomach or duodenum
- for injection sclerosis of esophageal varices or ligation of esophageal varices
- for insertion of plastic tube or stent

- for control of hemorrhage by coagulation or injection
- for ablation of tumor or mucosal lesion
- for dilation of gastric outlet obstruction or esophageal stricture
- for placement of percutaneous gastrostomy tube

ICD-9-CM Code(s):

| | |
|-----------------|---------------------------------------|
| 150.0 - 150.9 | Malignant neoplasms |
| 151.0 - 151.9 | |
| 152.0 - 152.1 | |
| 159.9 | |
| 199.0 | Disseminated neoplasms |
| 230.1 - 230.2 | Carcinoma in situ |
| 211.0 - 211.2 | Benign neoplasms and those of |
| 235.2 | uncertain behavior/unspecified |
| 239.0 | nature |
| 456.0 - 456.21 | Esophageal varices |
| 578.0 - 578.9 | GI bleeding, hemorrhage and melena |
| 531.00 - 531.91 | Gastric, duodenal, peptic and |
| 532.00 - 532.91 | gastrojejunal ulcers |
| 533.00 - 533.91 | |
| 534.00 - 534.91 | |
| 535.00 - 535.91 | Gastritis, duodenitis |
| 536.0 - 536.0 | Disorders of stomach, |
| 537.0 - 537.9 | duodenum |
| 750.3, 750.5 | Fistulas, atresia and stenosis |
| 747.61, 750.4 | Anomalies of upper GI tract |
| 750.7 - 750.9 | |
| 552.3, 553.3 | Hiatal hernias |
| 750.6 | |
| 793.4 | Filling defects |

Billing Instructions:

The basic diagnostic procedure (CPT 43200, CPT 43234, CPT 43235, CPT 43260) is inclusive in the more extensive procedures (CPT 43202-43228, CPT 43239 - 43259, CPT 43261 - 43272).

When a claim is submitted for biopsy(s) or polyp(s), the only code necessary to describe the care rendered is CPT 43239 or CPT 43251.

Although the provider may continue to state the number of biopsies or polyps removed, benefits are limited to one biopsy and/or one polypectomy and reimbursement is all inclusive in the primary endoscopic procedure. Separate benefits for additional biopsies/polypectomies are not available.

Dilatations are covered when performed for specific diagnoses of either stricture or stenosis of the specific anatomical site.

Control of hemorrhage at the biopsy or polypectomy site is reimbursed as part of the biopsy or polypectomy service; no additional reimbursement is available.

When UGI endoscopy is performed for directed placement of a Percutaneous Gastrostomy Tube (PEG Procedure), the procedure should be coded as follows:

The **complete procedure** involving one physician who performs **both** the **endoscopy** for directed placement of the tube and the **abdominal incision** should use **CPT 43246**.

The **endoscopy portion** billed by a physician who **only** performs the upper gastrointestinal **endoscopy** associated with the PEG procedure should use **CPT 43235**.

The **surgical portion** billed by a physician who **only** performs the abdominal incision for placement of the gastrostomy tube (PEG) should use **CPT 43750**.

Special rules have been established for payment for multiple endoscopies with the same base code. In some cases, such related endoscopies may be performed on the same day as other endoscopies or other surgical procedures. Some examples are as follows:

If two endoscopies performed the same day are unrelated (e.g., CPT 43235 and CPT 45378), the payment is made using the multiple surgery rules (i.e., 100% for the most expensive procedure, 50% for the next, etc.,).

When there are two upper and two lower endoscopies performed the same day (e.g., CPT 43239, CPT 43251, CPT 45380, and CPT 45385) two series of endoscopies have been performed and the special endoscopy rules will be applied to each series followed by the multiple surgical rules of 100% and 50%. Each set of codes with the same base code are first subject to the special endoscopy rules. The full value of the highest valued endoscopy plus the difference between the next

highest and the base endoscopy should be calculated for each set of codes. After this, the multiple surgical rules will be applied (e.g., 100% for the highest value series, 50% for the next set, etc.)

When there are two related endoscopies (CPT 43235 and CPT 43247) and a third unrelated endoscopy, (CPT 45380) the special endoscopic rules apply to the related endoscopies and then the multiple surgical rules are utilized, considering the total for the related endoscopies as one service and the unrelated endoscopy as another service.

Effective with claims received July 1, 1994 and after, the following billing instructions apply: The correct code for reporting a PEG is 43246. A PEG is a procedure that can be performed by a single physician - usually a gastroenterologist. However, because many hospitals require that the procedure be performed by a gastroenterologist and surgeon together, Medicare will pay for both physicians.

The correct method of reporting a PEG performed by two physicians is for both physician A and physician B to report 43246 with modifier -62 as co-surgeons. Usually physician A will be a gastroenterologist and physician B a surgeon. Although billing as co-surgeons is preferable, the billing as an assistant at surgery by physician B will still be permitted.

Some surgeons who have assisted gastroenterologists with PEGs have reported their services with code 43750 "Percutaneous placement of gastrostomy tube." This is incorrect coding. HCFA interprets code 43750 to represent the non-endoscopic placement of a gastrostomy tube which, following the development of endoscopic approach, is rarely performed. Surgeons who participate in the endoscopic placement of a percutaneous gastrostomy tube should not report their services with code 43750. As stated above, the correct code is 43246 with a co-surgeon modifier.

Barry S. Gold M.D.

Approved by:

Barry S. Gold, M.D., F.A.C.P.
Medical Director

Provider Notification:

Policy effective date 4/20/90 with revisions effective 12/31/92.

June 24, 1994 ICD-9-CM diagnosis codes added, CPT codes revised and slight verbiage changes made. Revisions and additions shown in [].

MEDICAL POLICY**SUBJECT: CHEMOTHERAPEUTIC DRUG COVERAGE****EFFECTIVE DATE: June 3, 1993****REVISED: April 1, 1994 and June 29, 1994**

CPT/HCPCS CODE(S): Refer to list which begins on page 741 for each chemotherapeutic agent. These are shown in ICD.9.CM "J" code order. An alphabetical listing is found on page 752.

Description of Service: Chemotherapy is the treatment of neoplastic disease by means of chemical substances or drugs.

Coverage Requirements: An off-label use (also referred to as an unlabeled use) of a drug is a use that is not included as an appropriate indication on the drug's official label as approved by the FDA.

Effective January 1, 1994, unlabeled uses of FDA approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen for a medically accepted indication are considered safe and effective. (A regimen is a combination of anti-cancer agents which have been clinically recognized for the treatment of a specific type of cancer).

NOTE: A cancer treatment regimen does not include drugs used to treat toxicities or side effects of the treatment regimen.

A medically accepted indication is one of the following:

1. A use approved by the FDA (labeled indication), or
2. A use supported by one or more citations in at least one of the three drug compendia listed below, and the use is not listed as "not" indicated in any of the three compendia:
 - a. American Hospital Formulary Service Drug Information
 - b. American Medical Association Drug Evaluations
 - c. United States Pharmacopoeia Drug Information (USPDI)
3. A use supported by clinical research that appears in peer-reviewed medical literature. (This applies only when an unlabeled use does not appear in any of the compendia, or is listed as "insufficient data" or "DVP" or "investigational."

The following is a list of frequently prescribed chemotherapeutic drugs reimbursed by Medicare for cancer chemotherapy. Both labeled and approved off-labeled diagnoses are listed. Off-labeled uses of FDA-approved drugs not otherwise excluded (such as self-administered drugs) will usually be reimbursed. The use must be considered reasonable and

necessary based on the coverage criteria described above. This list is not all-inclusive.

ICD.9.CM Code(s):

The diagnoses and the appropriate ICD.9.CM Codes are listed for each chemotherapeutic agent.

Leucovorin - J0640 in combination with Fluorouracil - J9190

| | |
|---|--|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colon and rectal cancer | 153.0-153.9, 154.0-154.8, 197.5 |
| Endometrial cancer | 182.0 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Head and neck cancer | 140.0-149.9, 195.0 |
| Liver cancer | 155.0-155.2, 197.7 |
| Lung cancer | 162.0-162.9 |
| Malignant pleural, peritoneal and pericardial effusion | 197.2, 197.6, 420.0, 420.90, 568.82 |
| Ovarian cancer | 183.0 |
| Prostate cancer | 185 |

Leucovorin - J0640 (rescue of high dose Methotrexate therapy)

| | |
|---|--|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Burkitt's lymphoma | 200.20-200.28 |
| Cervical cancer | 180.0-180.9 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteogenic sarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Prostatic cancer | 185 |
| Renal cancer | 189.0-189.1, 198.0 |
| Trophoblastic germ cell choriocarcinoma | 181 |
| Trophoblastic germ cell testicular carcinoma | 186.0, 186.9 |

Doxorubicin (Adriamycin) - J9000, J9010

| | |
|--------------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 205.80, 206.00, 206.80, 206.90 |
| Bladder cancer | 188.0-188.9 |
| Bone sarcomas | 170.0-170.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Ewing's sarcoma | 170.9 |

| | |
|---|---|
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Head and neck cancer | 140.0-149.9 |
| Liver cancer | 155.0-155.2, 197.7 |
| Hodgkin's disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Laryngeal cancer | 161.0-161.9 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| [Macroglobulinemias | 273.3] |
| Multiple myeloma | 203.00 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Neuroblastoma | 160.0-194.9 |
| Ovarian cancer | 183.0 |
| Pancreatic cancer | 157.0-157.9 |
| Prostate cancer | 185 |
| Soft tissue sarcomas | 171.0-171.9 |
| Trophoblastic germ cell testicular cancer | 186.0, 186.9 |
| Thymoma | 164.0 |
| Thyroid cancer | 193 |
| Uterine cancer | 182.0-182.8 |
| Vaginal cancer | 184.0 |
| Wilms' tumor | 189.0 |

Asparaginase - J9020 in combination with other antineoplastics (but not necessarily simultaneously)

| | |
|--------------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 205.80, 206.00, 206.80, 206.90 |
| Chronic myelogenous leukemia | 205.80 |
| Chronic lymphocytic leukemia | 204.10 |
| Hodgkin's disease | 201.00-201.90 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

BCG (Bacillus Calmette - Guerin) - J9031

| | |
|-------------------------------|-------------|
| Bladder cancer | 188.0-188.9 |
| Melanoma (malignant melanoma) | 172.0-172.9 |

Bleomycin Sulfate - J9040

| | |
|-------------------------------|---|
| Cervical cancer | 180.0, 180.9 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Head and neck cancer | 140.0-149.9, 195.0 |
| Hodgkin's disease | 201.0-210.90 |
| Kaposi's sarcoma | 042.2 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

| | |
|---------------------------------|--------------------|
| Osteosarcoma | 170.0-170.9 |
| Penile cancer | 187.1-187.4 |
| Renal cell cancer | 189.0-189.1, 198.0 |
| Reticulum cell sarcoma | 200.00-200.88 |
| Soft tissue sarcoma | 171.0-171.9 |
| Squamous cell cancer of skin | 173.0-173.9 |
| Trophoblastic testicular cancer | 186.0, 186.9 |
| Thyroid cancer | 193 |

Carboplatin - J9045

| | |
|---|---|
| Bladder cancer | 188.0-188.9 |
| Breast Cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Esophageal cancer | 150.9, 197.8 |
| Gastrointestinal cancer | 151.0-151.4, 151.9, 159.0-159.1, 197.4 |
| Head and neck cancer (soft tissue malignant tumor) | 140.0-149.9, 195.0 |
| Laryngeal cancer | 161.0-161.9 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Merkel's tumor | 173.8-173.9 |
| Neuroblastoma | 160.0-194.0 |
| Orbital cancer | 190.1 |
| Osteosarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Prostate cancer | 185 |
| Testicular cancer | 186.0-186.9 |
| Thyroid cancer | 193 |
| Urethral cancer | 188.6, 189.2-189.4 |
| Uterine cancer | 182.0-182.8 |

Carmustine (BCNU)- J9050

| | |
|-------------------------------|---|
| Astrocytoma | 191.9 |
| Colorectal cancer | 153.0-153.9, 154.0-154.8, 197.5 |
| Ewing's sarcoma | 170.9 |
| Glioblastoma | 191.9 |
| Hodgkins' disease | 201.00-201.90 |
| Liver cancer | 155.0-155.2, 197.7 |
| Lung cancer | 162.0-162.9 |
| Medullablastoma | 191.6 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Multiple myeloma | 203.00 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

Cisplatin - J9060, J9062

| | |
|-------------------------------|--|
| Adrenal cortex cancer | 194.0 |
| Astrocytoma | 191.9 |
| Bladder cancer | 188.0-188.9 |
| Bone sarcomas | 170.0-170.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Head and neck cancer | 140.0-149.9, 195.0 |
| Laryngeal cancer | 161.0-161.9 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Merkel's tumor | 173.8, 173.9 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Mesothelioma | 158.0-158.8, 163.0-163.9 |
| Neuroblastoma | 60.0-194.0 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteosarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Penile cancer | 187.1-187.4 |
| Prostate cancer | 185 |
| Skin cancer | 173.0-173.9 |
| Soft tissue cancer (sarcomas) | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |
| Thymoma | 164.0 |
| Urethral cancer | 188.6, 189.2-189.4 |
| Uterine cancer | 182.0-182.8 |

Cyclophosphamide (Cytosan) - J9070, J9080, J9090, J9091, J9092, J9094, J9095, J9096, J9097

| | |
|--------------------------------|--|
| Acute Lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 205.80, 206.00, 206.80, 206.90 |
| Bladder cancer | 188.0-188.9 |
| Cervical cancer | 180.0-180.9 |
| Endometrial cancer | 182.0 |
| Ewing's sarcoma | 170.9 |
| Head and neck cancer | 140.0-149.9, 195.0 |
| Hodgkin's disease | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| [Macroglobulinemias | 273.3] |
| Multiple Myeloma | 203.00 |
| Neuroblastoma | 160.0-194.0 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteosarcoma | 170.0-170.9 |

| | |
|--|--------------|
| Ovarian cancer (germ cell and non-germ cell) | 183.0 |
| Prostate cancer | 185 |
| Retinoblastoma | 190.5 |
| Soft tissue cancer | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |
| Uterine cancer | 182.0-182.8 |
| Wilms' tumor | 189.0 |

Cytarabine (Cytosar) - J9100, J9110

| | |
|-----------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute myelocytic leukemia | 205.00, 206.00 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Hodgkin's disease | 201.00-201.90 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

Dactinomycin (Actinomycin D) - J9120

| | |
|-------------------------------|--------------|
| Acute lymphocytic leukemia | 204.00 |
| Breast cancer | 174.0-175.9 |
| Endometrial cancer | 182.0 |
| Melanoma (malignant melanoma) | 172.0-172.9 |
| Ovarian cancer | 183.0 |
| Rhabdomyosarcoma | 171.0-171.9 |
| Sarcomas | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |
| Trophoblastic tumors in women | 181 |
| Wilms' tumor | 189.0 |

Dacarbazine (DTIC) - J9130, J9140

| | |
|--------------------|--------------------|
| Hodgkin's disease | 201.00-201.90 |
| Malignant melanoma | 172.0-172.9 |
| Neuroblastoma | 160.0-194.0 |
| Pancreatic cancer | 157.0-157.9, 197.8 |
| Sarcomas | 171.0-171.9 |

Daunorubicin - J9150

| | |
|--------------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute non-lymphocytic leukemia | 205.00, 205.80, 206.00, 206.80, 206.90 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Ewing's sarcoma | 170.9 |
| Neuroblastoma | 160.0-194.0 |
| Non-Hodgkin's lymphoma | 200.00-200., 202.00-202.08, 202.80-202.88 |
| Rhabdomyosarcoma | 171.0-171.9 |
| Wilms' tumor | 189.0 |

Diethylstilbestrol Diphosphate - J9165

| | |
|------------------|-------------|
| Breast cancer | 174.0-175.9 |
| Prostatic cancer | 185 |

Etoposide (VP16) - J9181, J9182

| | |
|----------------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute myelocytic leukemia | 205.00, 206.00 |
| Adrenal cortex cancer | 194.0 |
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Ewing's sarcoma | 170.9 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Germ cell ovarian cancer | 181 |
| Gestational trophoblastic cancer | 186.0, 186.9 |
| Glioma (brain) | 191.1 |
| Hodgkin's disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Liver cancer | 155.0-155.2, 197.7 |
| Lung cancer | 162.0-162.9 |
| Lymphoma | 196.0-196.9, 200.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |
| Soft tissue sarcomas | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |

[Fludarabine Phosphate (Fludara) - J9185]

| | |
|--|---|
| Chronic lymphocytic leukemia | 204.10 |
| Hairy cell leukemia | 202.40-202.48 |
| Refractory, low-grade non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |

Fluorouracil (5-FU) - J9190

| | |
|--------------------|---------------------------|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colorectal cancer | 153.0-154.8, 197.5 |
| Endometrial cancer | 182.0 |
| Esophageal cancer | 150.9, 197.8 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| Lung cancer | 162.0-162.9 |
| Ovarian cancer | 183.0 |
| Pancreatic cancer | 157.0-157.9, 197.8 |
| Prostate cancer | 185 |

Floxuridine (FUDR) - J9200

| | |
|----------------------------|--------------------|
| Acute lymphocytic leukemia | 204.00 |
| Acute myelocytic leukemia | 205.00, 206.00. |
| Bile duct cancer | 155.1, 156.1-156.9 |

| | |
|---------------------------------------|---------------------------|
| Bladder cancer | 188.0-188.9 |
| Brain cancer | 191.0-191.9, 192.1 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colorectal cancer | 153.0-154.8, 197.5 |
| Gall bladder cancer | 156.0-156.8 |
| Gastric cancer | 151.0-151.4, 151.9, 197.4 |
| GI adenocarcinoma metastatic to liver | 155.2, 159.9 |
| Head and neck cancer | 140.0-149.9, 195.0 |
| Liver cancer | 155.0-155.2, 197.7 |
| Lung cancer | 162.0-162.9 |
| Ovarian cancer | 183.0 |
| Prostate cancer | 185 |

Goserelin Acetate (Zoladex) - J9202

| | |
|-------------------------------|-------------|
| (Advanced) prostate cancer | 185 |
| (Premenopausal) breast cancer | 174.0-175.9 |
| Endometriosis | 617.0-617.9 |

(Effective for services on & after 2/2/93.)

Ifosfamide - J9208

| | |
|---|---|
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Connective and other soft tissue malignancies | 171.0-171.9 |
| Endometrial cancer | 182.0 |
| Ewing's sarcoma | 170.9 |
| Germ cell testicular cancer | 186.0, 186.9 |
| Hodgkin's disease | 201.00-201.90 |
| Leukemias (acute) | 204.0, 205.00, 206.00 |
| Lung cancer | 162.0-162.9 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |
| Pancreatic cancer | 157.0-157.9, 197.8 |
| Sarcomas | 171.0-171.9 |

Mesna - J9209

Given with Ifosfamide or Cytosan (refer to diagnoses listed under these chemotherapeutic agents).

Interferon - J9213-J9216

| | |
|------------------------------|--------------------|
| Bladder cancer | 188.0-188.9 |
| Brain cancer | 191.0-191.9, 192.1 |
| Cervical cancer | 180.0-180.9 |
| Chronic myelogenous leukemia | 205.80 |
| Chronic lymphocytic leukemia | 204.10 |
| Hairy cell leukemia | 202.40-202.48 |

| | |
|-------------------------------------|---|
| Head and neck cancer | 140.0-149.9, 195.0 |
| Hepatitis C | 070.51 |
| Hepatitis B | 070.30 |
| Hodgkin's disease | 201.00-201.90 |
| Internal and external genital warts | 078.1 |
| Kaposi's sarcoma | 042.2 |
| Malignant melanoma (melanoma) | 172.0-172.9 |
| Multiple myeloma | 203.00 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteosarcoma | 170.0-170.9 |
| Ovarian cancer | 183.0 |
| Skin cancer | 173.0-173.9 |
| Renal cell carcinoma | 189.0, 189.1, 198.0 |

Mechlorethamine HCL (Nitrogen Mustard) - J9230

| | |
|------------------------------|---|
| Brain cancer | 191.0-191.9, 192.1 |
| Breast cancer | 174.0-175.9 |
| Chronic lymphocytic leukemia | 204.10 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Hodgkin's disease | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Lymphosarcoma | 200.00-200.18, 200.80-200.88 |
| Non-Hodgkin's lymphomas | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |
| T-cell lymphoma, cutaneous | 173.0-173.9, 202.00 |

Medroxyprogesterone acetate (Depo-provera) - J9240

| | |
|--------------------|--------------------|
| Breast cancer | 174.0-175.9 |
| Endometrial cancer | 182.0 |
| Renal cancer | 189.0-189.1, 198.0 |

Methotrexate - J9250, J9260

| | |
|-----------------------------|---|
| Acute lymphocytic leukemia | 204.00 |
| Acute myelocytic leukemia | 205.00, 206.00 |
| Cutaneous T-cell lymphoma | 173.0-173.9, 202.00 |
| Gestational choriocarcinoma | 263.1 |
| Lymphosarcoma | 200.00-200.18, 200.80-200.88 |
| Multiple myeloma | 185 |
| Non-Hodgkin's lymphoma | 200.00-200.88, 202.00-202.08, 202.80-202.88 |
| Osteosarcoma | 170.0-170.9 |
| Sarcomas | 171.0-171.9 |
| Testicular cancer | 186.0, 186.9 |
| Trophoblastic tumors | 186.0, 186.9 |

Also used in combination with other antineopastics for bladder, brain, breast, cervical esophageal, gastric, head and neck, liver, lung, ovarian and prostate cancer. Refer to diagnosis codes listed under these chemotherapeutic agents.

Plicamycin (Mithramycin) - J9270

Testicular carcinoma 186.0-186.9

Mitomycin - J9280, J9290, J9291

Bladder cancer 188.0-188.9
 Breast cancer 174.0-175.9
 Cervical cancer 180.0-180.9
 Chronic myelocytic leukemia 205.10, 206.10
 Colorectal cancer 153.0-154.8, 197.5
 Esophageal cancer 150.9, 197.8
 Gallbladder cancer 156.0, 156.8
 Gastric cancer 151.0-151.4, 151.9, 197.4
 Head and neck cancer 140.0-149.9, 195.0
 Lung cancer 162.0-162.9
 Lymphoma 196.0-196.9, 200.00-202.08, 202.80-202.88
 Pancreatic cancer 157.0-157.9, 197.8

Mitoxantrone (Novantrone - J9293)

Acute non-lymphocytic leukemia 205.00, 205.80, 206.00, 206.80, 206.90
 Bladder cancer 188.0-188.9
 Breast cancer 174.0-175.9
 Cervical cancer 180.0-180.9
 Endometrial cancer 182.0
 Gastric cancer 151.0-151.4, 151.9, 197.7
 Liver cancer 155.0-155.2, 197.7
 Lung cancer 162.0-162.9
 Non-Hodgkin's lymphoma 200.00-200.88, 202.00-202.08, 202.80-202.88
 Ovarian cancer 183.0
 Pancreatic cancer 157.0-157.8, 197.8
 Prostate cancer 185
 Sarcomas 171.0-171.9
 Squamous cell cancer of head and neck 140.0-149.9, 195.0
 Testicular cancer 186.0, 186.9
 Thyroid cancer 193

Streptozocin - J9320

Acute lymphocytic leukemia 204.00
 Colorectal cancer 153.0-154.8, 197.5
 Hodgkin's disease 201.00-201.90
 Liver cancer 155.0-155.2, 197.7
 Lung cancer 162.0-162.9
 Melanoma (malignant melanoma) 172.0-172.9
 Metastatic islet cell carcinoma of pancreas 157.4

Thiotepa - J9340

| | |
|-------------------------|---|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Hodgkin's disease | 201.00-201.90 |
| Lung cancer | 162.0-162.9 |
| Meningeal cancer | 198.4 |
| Non-Hodgkin's lymphomas | 200.00-200.88,202.00-202.08, 202.80-202.88 |
| Ovarian cancer | 183.0 |

Vinblastine Sulfate (Velban) - J9360

| | |
|-----------------------------|---|
| Bladder cancer | 188.0-188.9 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Chronic myelocytic leukemia | 205.10, 206.10 |
| Germ cell testicular cancer | 186.0, 186.9 |
| Head and neck cancer | 140.0-149.9 |
| Hodgkin's Disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Kidney cancer | 189.0, 189.1, 198.0 |
| Lung cancer | 162.0-162.9 |
| Melanoma | 172.0-172.9 |
| Mycosis Fungoides | 202.10-202.18 |
| Neuroblastoma | 160.0-194.0 |
| Non-Hodgkin's lymphomas | 200.00-200.88,202.00-202.08, 202.80-202.88 |
| T-cell lymphoma | 173.0-173.9, 202.00 |

Vincristine Sulfate (Oncovin) - J9370, J9375, J9380

| | |
|-----------------------------------|---|
| All leukemias (acute and chronic) | 204.00-204.90,205.00- 205.90,206.00-206.90, 207.00, 207.80, 208.00-208.90 |
| Brain cancer | 191.0-191.9, 192.1 |
| Breast cancer | 174.0-175.9 |
| Cervical cancer | 180.0-180.9 |
| Colorectal cancer | 153.0-154.8, 197.5 |
| Ewing's sarcoma | 170.9 |
| Head and neck cancer | 140.0-149.9 |
| Hodgkin's disease | 201.00-201.90 |
| Kaposi's sarcoma | 042.2 |
| Lung cancer | 162.0-162.9 |
| [Macroglobulinemias | 273.3] |
| Non-Hodgkin's lymphomas | 200.00-200.88,202.00-202.08, 202.80-202.88 |
| Osteogenic and other sarcomas | 170.0-170.9,202.00-202.08, 202.60-202.68 |
| Renal cancer | 189.0-189.1, 198.0 |
| Rhabdomyosarcoma | 171.0-171.9 |
| T-cell lymphoma | 173.0-173.9, 202.00 |

MEDICAL POLICY MEDICAL POLICY MEDICAL POLICY MEDICAL POLICY

Wilms' tumor 189.0

Idarubicin - J9999

Acute monocytic leukemia 206.00
Acute myeloid leukemia 205.00, 205.80

Pentostatin - J9999

Chronic lymphocytic leukemia 204.10
Hairy cell leukemia 202.40-202.48

Proleukin - J9999

Melanoma (malignant melanoma) 172.0-172.9
Metastatic renal cell carcinoma 189.0-189.1, 198.0

Taxol - J9999

(Advanced) ovarian cancer 183.0
Breast cancer 174.0-175.9

Billing Instructions:

Effective January 1, 1994 claims for oral anti-cancer drugs submitted by a supplier are processed by the appropriate regional carrier. Refer to the regional carrier's medical policy guidelines.

Claims for oral anti-cancer drugs submitted by a provider are processed by the appropriate fiscal intermediary (FI). The term provider used here includes hospitals, rural primary care hospitals, skilled nursing facilities, comprehensive out-patient rehabilitation facilities, home health agencies and hospice programs.

Claims for injectable anti-cancer drugs furnished incident to a physician's service—and not self-administered—continue to be processed by this carrier.

Barry S. Gold M.D.

Approved by:

Barry S. Gold, M.D., F.A.C.P.
Medical Director

Provider Notification:

Revised policy guidelines which include ICD.9.CM codes to Carrier Advisory Committee (CAC) March 16, 1994.

Corrected copy mailed to CAC Representatives April 1, 1994.

Updated policy guidelines to CAC June 29, 1994.

ALPHA INDEX OF CHEMOTHERAPEUTIC AGENTS

| | |
|---|--|
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| Plicamycin (Mithramycin) | J9270 |
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| Taxol | J9999 |
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| Vincristine Sulfate (Oncovin) | J9370, J9375, J9380 |

HCPCS CODE INDEX OF CHEMOTHERAPEUTIC AGENTS

| | |
|---------------------|--|
| J0640 | Leucovorin, also in combination with 5-FU and in rescue of high-dose methotreate therapy) |
| J9010 | Doxorubicin (Adriamycin) |
| J9020 | Asparaginase (in combination with other Antineoplastics but not necessarily simutaneously) |
| J9031 | BCG (Bacillus Calmette - Guerin) |
| J9040 | Bleomycin Sulfate |
| J9045 | Carboplatin |
| J9050 | Carmustine (BCNU) |
| J9060, J9062 | Cisplatin |
| J9070, J9080, J9090 | Cyclophosphamide (Cytosan)(also J9091, and |
| J9092-J9097) | |
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| J9120 | Dactinomycin (Actinomycin D) |
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| J9208 | Ifosfamide |
| J9209 | Mesna |
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| J9230 | Mechlorethamine HCL (Nitrogen Mustard) |
| J9240 | Medroxyprogesterone Acetate (Depo-Provera) |
| J9250, J9260 | Methotrexate |
| J9270 | Plicamycin (Mithramycin) |
| J9280, J9290, J9291 | Mitomycin |
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| J9370, J9375, J9380 | Vincristine Sulfate (Oncovin) |
| J9999 | Fludarabine, Idarubicin, Pentostatin, Proleukin, Taxol |

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Information for AUTHORS

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• **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

• **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

• **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of

corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

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The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

- | | |
|---|------------------------|
| Ophthalmology for the pediatrician. Cat 1 AMA credits available. Fee: \$125/physicians; \$95/residents, fellows and allied health professionals. | Sept. 16 |
| Airway management: Hands-on workshops, case management colloquia, and difficult airway/intubation alert. Cat 1 AMA/PRA credits available. Fee: \$650. | Sept. 23-25 |
| Pediatrics for practitioner update '94. 14 Cat 1 AMA credits. Fee: \$290/physicians; \$190/residents*, retired physicians, allied health professionals, fellows* (with letter). | Sept. 29-30 |
| 20th anniversary: Annual topics in gastroenterology and liver disease. Cat 1 AMA credits. Fee: \$495 physicians; \$250 residents and fellows (with letter from department chairperson verifying status). | Oct. 5-7 |
| Eighth annual core content of emergency medicine: A comprehensive review, at the Marriott Hotel, BWI Airport, Baltimore, MD. 76.5 Cat 1 AMA credits, 3 Cat 1 AMA credits for optional wound closure workshop, 74.5 ACEP Cat 1 credits, 70.75 AAFP prescribed hours. Fee: \$1,000/physicians (\$1,100 after Sept. 1), \$800/residents/fellows (\$1,100 after Sept. 1). | Oct. 6-13 |
| Flexible sigmoidoscopy | Oct. 8 |
| 36th annual Emil Novak memorial course: Gynecology, gynecological pathology, endocrinology and high risk obstetrics and first annual Richard W. Telinde lecture. | Oct. 15-20 |
| Diabetic retinopathy and venous occlusive disease. | Oct. 21-22 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA credits available. Fee: \$500 lectures, \$500 each additional lab, \$200 lectures for fellows and allied health professionals. | Oct. 24-26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27-30 |
| Update on sinusitis for the practitioner. | Oct. 28 |
| Advanced pediatric life support courses, 20 Cat 1 AMA credits. Fee: \$525. | Oct. 31-Nov. 2; |
| Advances in pediatric nutrition, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: \$200/physicians and allied health professionals; \$150/residents and fellows. | June 12-14 |
| | Nov. 14-16 |
| Memory and reality: Reconciliation. Scientific, clinical and legal issues of false memory syndrome, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: Postmarked before Oct. 1: \$300/professionals; \$125 families (includes 2 family members), postmarked after Oct. 1: \$400/professionals; \$275 families (includes 2 family members). | Dec. 9-11 |
| Basic comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. \$850/labs and lectures, \$325/lectures only. | Jan. 12 |
| Advanced comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. \$1400/labs and lectures, \$495/lectures only. | Jan. 13-14 |

The Johns Hopkins Medical Institutions (continued)

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Endocrinology update for the practicing physician 1994, at Harrisons Pier 5, Baltimore, MD. 10 Cat 1 AMA credits. Fee: \$175/physicians; \$100/residents and fellows. Info: Dorothy Taylor 410-328-2515. **Oct. 7-8**

R. Adams Cowley 16th annual national trauma symposium, at the Hyatt Regency, in Baltimore, MD. Info: 410-328-2399. **Nov. 16-20**

Miscellaneous meetings

Trials and Deliberations in Medicine. Attendants receive a 5% discount on 1995 Med Mutual renewal premiums and 2 Cat 1 AMA/PRA credits. Fee: \$40.00. Info: Toni Davis or Natalie Harper, 410-785-0050.

Patuxent Medical Group, Columbia **Sept. 1**

Harford Memorial, Havre de Grace **Sept. 6**

Medical Mutual, Hunt Valley **Sept. 7**

Anne Arundel Med. Ctr., Annapolis **Sept. 8**

Medical Mutual, Hunt Valley **Sept. 12**

Doctor's Comm. Hosp., Lanham **Sept. 13**

Holy Cross Hosp., Silver Spring **Sept. 20**

Medical Mutual, Hunt Valley **Sept. 21**

Frederick Memorial, Frederick **Sept. 22**

Women's health research topic, sponsored by the Baltimore City Medical Society at the Montebello Rehabilitation Hospital. 1 Cat 1 AMA Credit, Fee: Free. Info: 410-625-0022. **Sept. 1**

Miscellaneous meetings (continued)

- Current concepts in wound healing**, sponsored by the American Physical Therapy Association of Maryland, Inc., at the Holiday Inn-Inner Harbor, Baltimore, MD. Info: JoAnne Lyons Wooten, 301-808-9418. **Sept. 10-11**
- Psychological assesment of dissociative disorders in children, adolescents and adults**, at the Sheppard Pratt Conference Center, Baltimore, MD. 3.7 Cat 1 AMA/PRA credits. Fee: \$50.00. Info: 410-938-4598. **Sept. 22**
- Dissociative disorders: Rigorous assessment and responsible treatment in the 1990s**, at the Sheppard Pratt Conference Center, Baltimore, MD. 13.75 Cat 1 AMA/PRA credits. Fee: \$260. Info: 410-938-4598. **Sept. 23-24**
- Diabetic retinopathy: A comprehensive review and update**, sponsored by The American Diabetes Assoc. and The Retina Institute of MD, at the Stouffer Harborplace Hotel, Baltimore. 7.5 Cat 1 AMA Credits. Fee: \$275/physicians, \$100/fellows, residents, and allied health professionals. Info: 410-337-4500. **Sept. 23**
- Hematology board review course**, sponsored by the George Washington University Medical Center, at the Ritz-Carlton, in Pentagon City, VA. Info: Maria Gorrick, 202-994-4285. **Oct.**
- Network approach to provision of health care**, sponsored by the Baltimore City Medical Society at the Good Samaritan Hospital. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. **Oct. 6**
- Second annual gynecology CME course**, at the Plaza Hotel in NY, 13.5 Cat 1 AMA credits. Fee: \$495/physicians; \$295/physicians-in-training and allied health professionals. Info: Svetlana Lisanti, 201-385-8080. **Oct. 15-17**
- Annual business meeting**, sponsored by the Baltimore City Medical Society at UMMS Davidge Hall. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. **Nov. 3**
- Interface: Medicine Psychiatry**, sponsored by Saint Joseph Hospital at the Noppenberger Auditorium, Saint Josphe Hospital, Towson, MD. 6 Cat 1 AMA/PRA/AAFP credits. Fee: \$45/physicians, \$45/psychologists, \$25/house staff, nurses, allied health professionals. Info: Patricia Fuchsluger 410-337-1501. **Nov. 5**
- Evaluation of shoulder dysfunction and pain**, sponsored by the Omni Physical Therapy and Allsports Therapy Center in conjunction with Anne Arundel Medical Center to be held at the Comfort Inn in Bowie, MD. 3 Cat 1 AMA credits. Fee: \$50.00. Info: 301-474-6505. **Nov. 12**
- Clinical innovations in OB/GYN ultrasound**, sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine at the Lowes L'Enfant Plaza in Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learing Cognates by ACOB/GYN. Info: Ann Boehme 516-561-4223. **April 22-23**

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, Maryland, first and third Mondays of each month, 8:00-9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, Maryland. Info: 301-279-6115.

| | |
|--|----------|
| Drug interaction in the elderly | Sept. 1 |
| Tumor conference | Sept. 8 |
| Update diabetic retinopathy | Sept. 22 |
| Standards of care for patients with COPD | Sept. 29 |
| Imaging update | Oct. 6 |
| Tumor conference | Oct. 13 |
| Pancreatic cancer—New therapies | Oct. 20 |
| Boundary issues | Oct. 27 |
| Pediatric urology | Nov. 3 |
| Tumor conference | Nov. 10 |
| OB/GYN topic | Dec. 1 |
| Tumor conference | Dec. 8 |
| Infectious disease topic | Dec. 15 |



PHYSICIAN'S RECOGNITION AWARD

During July 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Palma Abraham, M.D.
Alvin Abrams, M.D.
Morton Altschuler, M.D.
Till Bergemann, M.D.
Philip R. Bowman, M.D.
Charles A. Cefalu, M.D.
Kailash Chopra, M.D.
Amy L. Compton-Phillips, M.D.
Joseph R. Cowen, M.D.

Tammi D. Davis, M.D.
Anand M. Dhanda, M.D.
Nabil A. El-Shammaa, M.D.
Najla N. Falaki, M.D.
Carol M. Gonzalez, M.D.
Eugene Guazzo, M.D.
Mark J. Jaffe, M.D.
Niranjan N. Jani, M.D.
Byoung-Kie Lee, M.D.

Lawrence S. Linder, M.D.
Mary E. Lindsay, M.D.
Rolando Mascardo, M.D.
Richard J. Nasca, M.D.
Juhi F. Nayeem, M.D.
Julio C. Novoa, M.D.
Bao T. Pham, M.D.
David Shore, M.D.
Paul G. Ventry, M.D.

William Donald Schaefer - Governor of Maryland



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J. Mehser Joseph, PhD - Director
Community Health Surveillance & Laboratories Admin

Ebenezer Israel, MD, MPH - Director
Epidemiology & Disease Control Program

August, 1994

Selected Communicable Diseases in Maryland in 1993

This report describes the epidemiology of selected communicable diseases with onset of illness in 1993 in Maryland. It is based on data collected through the communicable diseases reporting system. In addition, cases of investigated death certificates from the Department of Health and Mental Hygiene (DHMH) Center for Health Statistics that listed infectious diseases as a cause of death were added, along with investigated laboratory reports showing evidence of certain diseases, including amebiasis, gonococcal infection, *Haemophilus influenzae* invasive disease, viral hepatitis, legionellosis, Lyme disease, malaria, meningococcal disease, nontuberculous mycobacteriosis, Rocky Mountain spotted fever, salmonellosis, shigellosis, and syphilis. Even though *Campylobacter* infections, giardiasis, listeriosis, non-cholera *Vibrio* infections (non-O1), and yersiniosis are not on the list of notifiable diseases, morbidity and laboratory reports that we received were included in Table 1 of this report.

The communicable diseases data are entered into the computer-based MERSS (Maryland Electronic Reporting and Surveillance System) either centrally or at 20 of the 24 local health departments and electronically transmitted to the Division of Communicable Disease Surveillance at the DHMH Epidemiology and Disease Control Program. The data are then transmitted weekly to the Centers for Disease Control and Prevention (CDC) for our

report to the Morbidity and Mortality Weekly Report (MMWR). MERSS, with its comprehensive coding system for general and disease-specific variables important for epidemiology and control of disease, has allowed us to do more meaningful analysis of the data.

In this report the number in parenthesis after the name in the title of each disease indicates the number of cases in Maryland in 1993. Below the disease name are the incidence rates in Maryland and in the United States. The rates in Maryland are based on the 1993 population projections (Maryland Office of Planning - Total Population Projections by Age, Sex, and Race. Revision 6/94). The incidence rates in the United States are based on the 1993 population projection, obtained from the U.S. Bureau of the Census, and the cumulative number of cases reported to the MMWR system in 1993 (CDC. MMWR, January 7, 1994, Vol. 42, Nos. 51 & 52).

The prompt, accurate, and complete reporting by physicians, other health care providers, hospitals, laboratories, etc., is extremely important for achieving our goal to describe and control communicable diseases in Maryland. We gratefully acknowledge the cooperation of all those who contributed to communicable diseases surveillance in Maryland and in the U.S. by reporting, investigating, and collecting additional pertinent information.

BOTULISM, INFANT (1)
0.02/100,000 (U.S. 0.02/100,000)

Clostridium botulinum type B was recovered from the stool culture of a four month old hypotonic baby, with weak cry, poor sucking, weight loss, and constipation. The symptoms occurred a few weeks before hospitalization. After treatment the patient fully recovered. The source of infection was not identified.

ENCEPHALITIS, PRIMARY AND POST-INFECTIOUS (25)
0.5/100,000 (U.S. 0.4/100,000)

The incidence rate per 100,000 population in 1993 remained unchanged from the rate in 1992 (0.5). The number of cases by county is shown in Table 1. The highest rate per 100,000 population occurred in Dorchester (6.6), Caroline (3.6), and Talbot (3.2) counties. Twelve cases (48.0%) had onset of illness in June, July and August.

The male to female ratio was 0.6:1.0; the ratio of whites to blacks was 2.4:1.0. The age of the patients ranged from 25 days through 90 years (median 20 years); 5 cases (20.0%) were less than one year of age.

Herpes viruses (9 cases, including 2 post-varicella), cytomegalovirus (1), and untyped enterovirus (1) caused or were suspected to have caused 11 of the cases; the cause for the rest was not identified. One of the 18 patients for whom the status was known died for a case fatality rate of 5.6%. No arboviral encephalitis was reported in 1993.

GNOCOCCAL INFECTIONS (13,832)
277.5/100,000 (U.S. 152.1/100,000)

Reported gonococcal infections decreased by 16% from the number in 1992 (16,513). The cases by jurisdiction are shown in Table 1. Baltimore City noted an 18% decrease from 1992 and the rate in the counties (exclud-

ing Baltimore City) decreased by 13%, continuing the remarkable 10 year downward trend (Figure 1).

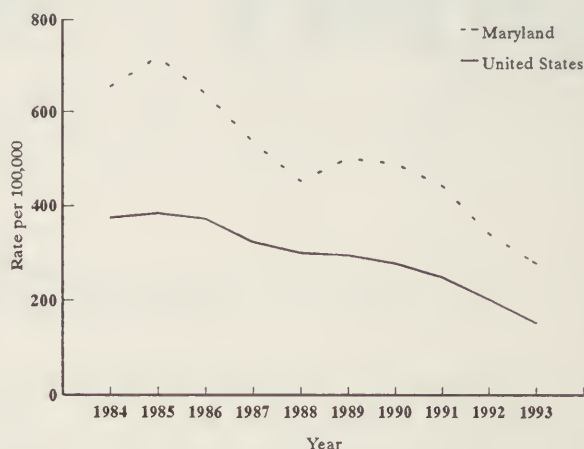


Fig 1. Gonococcal Infection. Incidence Rates in Maryland and the United States, 1984-1993.

Sixty-five percent of cases were Baltimore City residents accounting for the highest rate per 100,000 population (1231.4) in the State. Counties with high rates were Dorchester (405.9), Prince George's (303.5), and Wicomico (242.6). The age distribution of the cases in 1993 was similar to that in 1992, with 82% of the cases 15 to 34 years old. The rates per 100,000 population by age group and sex are shown in Figure 2.

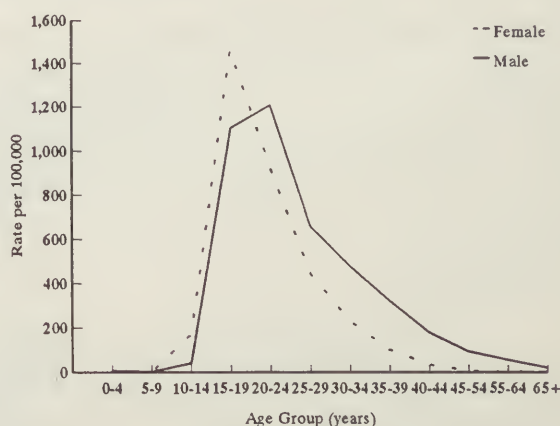



Fig 2. Gonococcal Infection. Incidence Rates by Age Group and Sex, Maryland, 1993.

Among the 9,366 cases for whom race was reported, 95% of the males and 90% of the females with gonorrhea were black.

To be continued September, 1994.

Table 1. Reported Cases of Notifiable Diseases in Maryland by County with Onset Date in 1993 Continued

|  | | | Jurisdiction | Population | Amebiasis | Anthrax | Botulism | Brucellosis | Campylobacteriosis | Cholera | Giardiasis | Kawasaki Syndrome | Legionellosis | Leprosy | Leptospirosis | Listeriosis | Malaria | Mycobacteriosis, Atypical | Newborn Infection | Plague | Polio myelitis | Psittacosis | S. typhi Carrier | Tetanus | Trichinosis | Tularemia | Typhus, Murine | Vibrio (Non-O1) Infection | Yersiniosis |
|--|--|--|---------------------|------------|-----------|---------|----------|-------------|--------------------|---------|------------|-------------------|---------------|---------|---------------|-------------|---------|---------------------------|-------------------|--------|----------------|-------------|------------------|---------|-------------|-----------|----------------|---------------------------|-------------|
| | | | Allegany | 74,979 | 1 | | | | 2 | | 12 | 4 | 2 | | | 1 | 2 | 4 | 5 | | | 1 | | | | | | | 2 |
| | | | Anne Arundel | 438,696 | | | | | 18 | | 30 | 3 | 8 | | | 1 | 4 | 35 | 38 | | | | | | | | | 1 | 12 |
| | | | Baltimore City | 724,378 | 1 | | | | 50 | | 5 | 3 | 12 | | | | 1 | 45 | 21 | | | | | | | | | | |
| | | | Baltimore Co. | 696,490 | | | | | | | 2 | 1 | 1 | | | | | 2 | | | | | | | | | | | |
| | | | Calvert | 58,095 | | | | | | | 2 | | | | | | | | | | | | | | | | | | |
| | | | Caroline | 27,980 | | | | | 7 | | 2 | | | | | 2 | | 2 | | | | | | | | | | | |
| | | | Carroll | 129,778 | | | | | 12 | | 5 | 1 | 2 | | | | | 3 | 1 | | | | | | | | | | |
| | | | Cecil | 74,711 | | | | | 5 | | 6 | | | | | | | 4 | | | | | | | | | | | |
| | | | Charles | 110,927 | | | | | 3 | | 2 | | 1 | | | | | 1 | | | | | | 1 | | | | | |
| | | | Dorchester | 30,523 | | | | | | | | | 2 | | | | | 1 | | | | | | | | | | | |
| | | | Frederick | 166,056 | | | | | 3 | | 6 | 2 | 6 | | | 1 | 2 | 14 | 3 | | | | | | | | | | |
| | | | Garrett | 28,615 | | | | | | | 1 | | | | | | | | | | | | | | | | | | |
| | | | Harford | 197,599 | 2 | | | | 6 | | | 1 | 6 | | | | | 13 | 10 | | | | | | | | | | 1 |
| | | | Howard | 203,043 | | | | | 5 | | 9 | 1 | 2 | | | | 5 | 8 | 3 | | | | | | | | | | |
| | | | Kent | 18,076 | | | | | 1 | | 1 | | | | | | 1 | 2 | | | | | | | | | | | |
| | | | Montgomery | 773,676 | 4 | | | | 1 | | | 2 | 3 | | | | 19 | 87 | 13 | | | | | | | | | | 3 |
| | | | Prince George's | 753,083 | 1 | | 1 | | 9 | | 12 | 9 | 5 | 1 | 3 | 22 | 89 | 31 | | | | | | 1 | | | | | 2 |
| | | | Queen Anne's | 36,491 | | | | | 1 | | | | | | | 1 | 3 | | | | | | | | | | | | |
| | | | Saint Mary's | 80,876 | | | | | 1 | | 1 | 2 | 1 | | 1 | | | 2 | 1 | | | | | | | | | | |
| | | | Somerset | 24,152 | | | | | | | | | | | | | | 9 | | | | | | | | | | | |
| | | | Talbot | 31,413 | | | | | 4 | | | | | | | | | | | | | 1 | | | | | | | |
| | | | Washington | 124,599 | | | | | 2 | | 2 | 1 | | | | | | 7 | | | | | 1 | | | | | | |
| | | | Wicomico | 76,657 | | | | | 2 | | 6 | | | | | | 1 | 24 | 2 | | | | | | | | | | |
| | | | Worcester | 36,550 | | | | | 9 | | 5 | | 1 | | | | | 17 | 2 | | | | | | | | | | 1 |
| | | | Not Stated | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Maryland Total | 4,917,443 | 9 | 0 | 1 | 0 | 141 | 0 | 107 | 30 | 52 | 0 | 1 | 9 | 58 | 695 | 133 | 0 | 1 | 1 | 1 | 1 | 2 | 0 | 0 | 1 | 24 |
| | | | Maryland Totals for | 1992 | 10 | | 1 | | 150 | 3 | 69 | 26 | 39 | | | 25 | 61 | 577 | 136 | | | 2 | 4 | | | 3 | 1 | 5 | 23 |
| | | | | 1991 | 9 | | | | 119 | 4 | 90 | 17 | 34 | 5 | | 2 | 62 | 507 | 84 | | 1 | 5 | 2 | 1 | | 2 | | 2 | 28 |
| | | | Prior Years | 1990 | 8 | | 7 | | 128 | | 58 | 17 | 48 | 1 | 1 | 5 | 57 | 473 | 30 | 1 | | 2 | 1 | | | | | 6 | 39 |
| | | | | 1989 | 9 | | 1 | | 279 | | 89 | 20 | 35 | | 1 | 7 | 42 | 314 | 158 | | 1 | 2 | 1 | 1 | | 2 | | | 34 |

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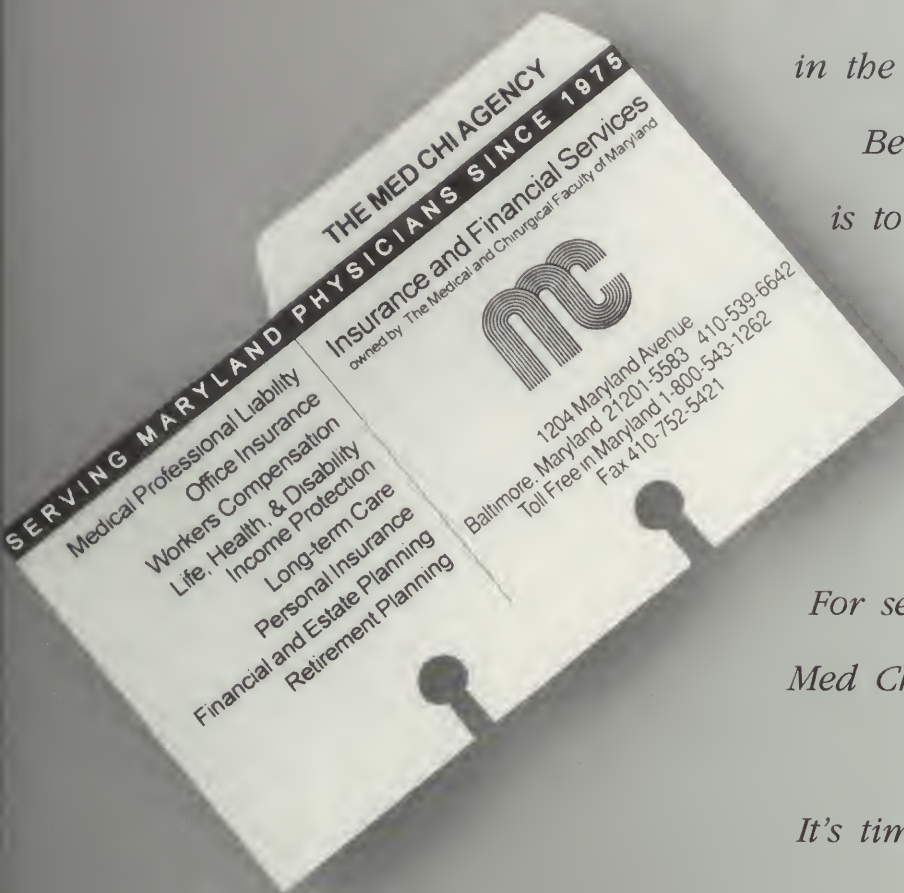
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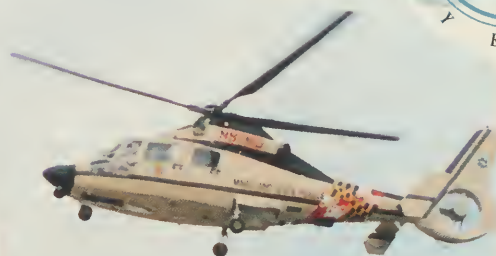
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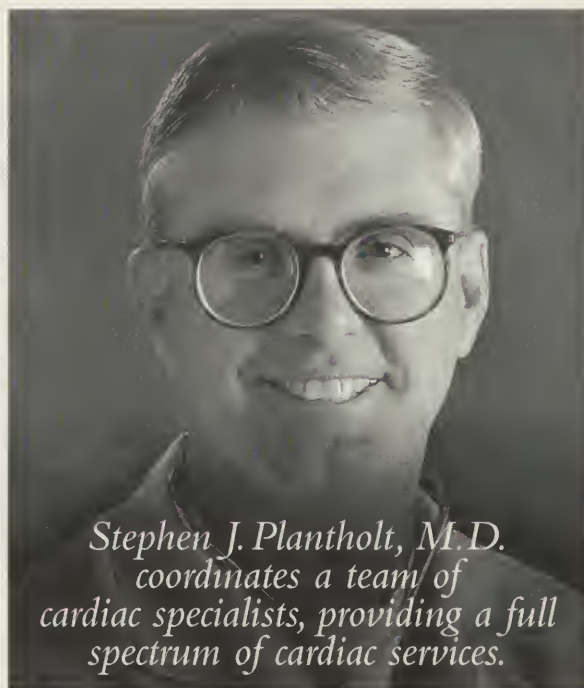
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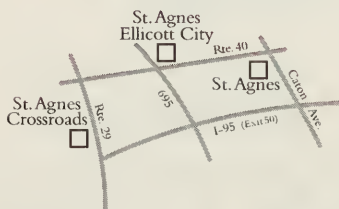
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President's Eastern Regional Conference

Thursday, November 10, 1994

Cambridge Yacht Club, Cambridge, Maryland

For more information on the president's regional conferences, contact Joan Mannion at 410-539-0872 or 1-800-492-1056.

Med Chi Information Hotline

The Med Chi Information Hotline has added the "progress in development of statewide network (IPAs)" to the information available. The mailboxes are currently assigned as follows:

- 1 federal health care reform updates
- 2 key state legislative issues in Annapolis
- 3 status of house bills
- 4 patient access/any willing provider
- 5 wrongful death legislation
- 6 progress in development of statewide network (IPAs)
- 7 managed care issues
- 8 events and important dates

To access this information 7 days a week, 24 hours a day, call 1-800-209-9126. Information will be updated as necessary during the upcoming legislative session. A current directory is always available on the hotline.

Awards for Excellence in Medical Journalism Announced

The following were selected to receive the 1993-1994 Awards for Excellence in Medical Journalism.

Daily Newspapers

First Place:

"Perimenopause"

Linell Smith

The Sun

Second Place:

"Survival Tactics"

Linell Smith

The Sun

Magazines and Non-daily Newspapers

First Place:

"The Painful Legacy of Agent Orange"

Diane Brown

Howard County Times

Second Place:

"A Face in the Crowd: One in Eight Americans Experience Depression"

Diane Brown

Columbia Flier

Honorable Mention:

"The Doctor Is In: Schmoke Inches Toward His 'Medicalization'
Approach to Drug Reform

Van Smith

City Paper

Radio

First Place:

"Sounds Like Addiction"

John Stupak

Consultation Radio Network

This year, Med Chi is making a \$500 donation to the charities designated by each of the first place winners. The charities chosen were:

Linell Smith – Chesapeake AIDS Foundation, Inc., a non-profit corporation that raises and administers funds for HIV/AIDS assistance programs in Maryland.

Diane Brown – divided the award between the Chase-Brexton Clinic, a clinic that provides primary health care services for HIV infected individuals, and the Leukemia Research Foundation Memorial Fund in memory of her brother Jeffrey Bland.

John Stupak – the Alumni Scholarship Assistance Program of the Father Martin's Ashley treatment center for alcoholism and chemical addiction.

Copies of these articles can be obtained by calling Ruth Seaby at 410-539-0872 or 1-800-492-1056 ext. 340.

*First-ever AMA
Television
Commercials*

Cable News Network (CNN) and CNBS will run the first-ever AMA television commercial from September 13 - October 7, 1994. The ad campaign focuses on health system reform and in the ad the AMA promises "to keep working with Congress to make sure health system reform" is passed that protects patient rights, quality care and the patient-physician relationship. The 60-second spot features AMA President Robert E. McAfee, M.D.

*AMA POWER
Network Offers Toll-
free Hotline on
Reform*

The AMA has created a toll-free hotline offering physicians daily, up-to-the-minute updates on the status of health system reform in Congress. The AMA POWER (Physicians Organized to Work for Effective Reform) Network hotline number is 800-833-6354 (in Washington, DC, call 202-408-7678).

*September is Women
in Medicine Month*

The American Medical Association is celebrating the fourth annual Women in Medicine Month. This campaign is designed to celebrate the achievements of women physicians and promote increased participation and leadership opportunities for women in the profession and in organized medicine. This year's theme is "Women Physicians on the Move."

A related note: For the first time in its 101-year history, more women than men reported for freshman year at the Johns Hopkins University School of Medicine when classes began September 6.

*Address Change
Reminder — Med Chi
Members*

Production of the 1994-1995 Med Chi Membership Directory will begin soon. If you have changed your address and have not yet notified Med Chi, please notify Wanda Griebel in the membership department at 410-539-0872 or 1-800-492-1056. If no changes are communicated, the address currently on file will be printed in the new directory.

*Baltimore Magazine to
Publish Consumer
Guide to Health Care
for the Greater
Baltimore Area*

Baltimore Magazine is planning to publish a guide to health care for the greater Baltimore area. The guide entitled **Health Smart '95** will be released in January 1995 and include a directory of paid doctor's listings. The deadline for placing a listing is November 15, 1994. For more information, including listing rates, call Jessica LaCosta, *Baltimore Magazine*, 410-752-3577 or 1-800-935-0838.

Med Chi is providing this notice as a service for our members and this notice should not be interpreted as an endorsement for this publication.

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Med Chi would like to thank the following companies for exhibiting at the 1994 Med Chi Semiannual Meeting:

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| <i>American Medical Association/ Educational & Research Foundation</i> | <i>Medical Mutual Liability Insurance Society of Maryland</i> |
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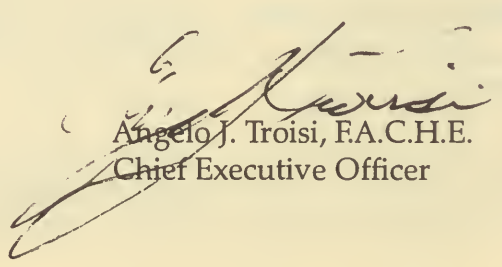
Sheraton Ocean City Resort and Conference Center

Med•Lantic Management, Inc.

Errata

In the August 1994 issue of the *Chief Executive Officer's Newsletter*, page 647, the House of Delegates' approval of a Bylaws Committee recommendation was inaccurately stated. The recommendation, as approved by the House of Delegates on July 21, 1994, should have read:

- 7.20 Composition. The Board of Trustees shall be composed of:
- b. Speaker of the House of Delegates
 - c. Vice speaker of the House of Delegates



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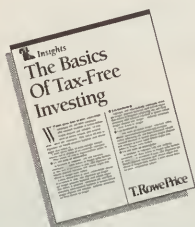
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**Within the category of Maryland Municipal Debt Funds, the Maryland Tax-Free Bond Fund was ranked #4 out of 16 funds based on total returns by Lipper Analytical Services for the 1-year period ending 6/30/94, with the top 3 positions being occupied by load funds. The Fund was also ranked #2 out of 7 and #2 out of 5 for the 5-year and since inception (3/31/87) periods ended 6/30/94, respectively. Request a prospectus with more complete information, including management fees and other charges and expenses. Read it carefully before you invest or send money. T. Rowe Price Investment Services, Inc., Distributor.

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Members in the News



CHRISTINE A. MARINO, M.D., was installed as president of the Maryland Academy of Family Physicians. Dr. Marino, a native of Troy, New York, practices family medicine in Laurel, Maryland. She is a clinical assistant professor in family medicine at the University of Maryland School of Medicine and was appointed by

Governor Schaefer to serve on the Committee on Practice Parameters of the Maryland Health Care Access and Cost Containment Commission. A diplomate of the American Board of Family Practice, Dr. Marino graduated summa cum laude with a bachelor of science degree in chemistry from the College of New Rochelle, New York. She earned her medical degree at the State University of New York at Buffalo School of Medicine and completed her internship and residencies at the University of Maryland Hospital.



D. WILLIAM SCHLOTT, M.D., recently named the first Philip A. Tumulty Associate Professor of Internal Medicine at The Johns Hopkins University School of Medicine, assumed his position on the full-time faculty in July. Dr. Schlott received his bachelor of science degree from Ohio University and his medical degree from Hopkins. Following

an internship at Hopkins Hospital, he trained at the National Cancer Institute, returned to Hopkins for his residency, then served two years as assistant professor in the department of medicine at the University of Connecticut. He returned to Hopkins in 1969, where, in addition to his medical practice, he has served as both assistant and associate professor of medicine. A diplomate of the American Board of Internal Medicine, Dr. Schlott is a member of the American College of Physicians and the American Society of Internal Medicine.



JOHN D. STOBO, M.D., former William Osler professor and director of the department of medicine at Hopkins, has been named vice dean for clinical sciences of The Johns Hopkins University School of Medicine, associate vice president for medicine of The Johns Hopkins University, and vice president of

the Johns Hopkins Health System. An immunologist whose research interests have included arthritis, diabetes, inflammatory bowel disease, and autoimmune disorders, Dr. Stobo was assistant professor of immunology at the Mayo Clinic in Rochester, New York, and associate professor of medicine and head of the rheumatology-clinical immunology section at the University of California at San Francisco. He is a fellow of the American College of Physicians, a past president of the American College of Rheumatology, and current president of the Association of Professors of Medicine. An author or co-author of numerous scientific articles, Dr. Stobo serves on the publications committee of the *Journal of Immunology* and the editorial board of *Clinical Aspects of Autoimmunity*. He received his undergraduate degree from Dartmouth College and his medical degree from the State University of New York at Buffalo. He served his internship and residencies at Hopkins.



DONALD E. WILSON, M.D., dean of the University of Maryland School of Medicine and chairperson of the Department of Health and Human Services' Advisory Council for Health Care Policy and Research, has been elected a master of the American College of Physicians. Of the College's 83,562 members, only 256 hold

the title of master. Dr. Wilson was elected in recognition of his contributions as a gastroenterologist, scholar, educator, and role model for African-American medical students and residents. Before coming to Maryland, Dr. Wilson was professor and chairperson of the department of medicine at the State University of New York Health Science Center at Brooklyn, as well as physician-in-chief at the University Hospital of Brooklyn and Kings County Hospital Medical Center in Brooklyn. He has written over 100 published scientific articles and served on the editorial boards of several medical journals. A member of numerous medical societies, Dr. Wilson is a co-founder of the Association of Academic Minority Physicians. He completed his undergraduate education at Harvard University and earned his medical degree at Tufts University School of Medicine. Dr. Wilson was the first African-American dean of an accredited medical school that is not predominantly minority.

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Improving the image of the medical profession

For the last several years, variations in the social and economic climate of the country, concerns about the health care system, the high cost of health services, and the lack of access to the expected levels of health care by some people have led to indictment of the medical profession. Accusations of indifference, fraud, greediness, selfishness, and non-adherence to the Hippocratic oath have surfaced. Articles and news items negative to the medical profession continue to appear in newspapers, lay magazines, radio, and television. The image of the physician has been tarnished and damaged in the eyes of many people.

Our profession, however, is a noble one. Long hours of dedicated work and study, compassion, and care for patients and attendance to their needs and welfare are the characteristics and the driving force of most physicians.

It is time that a concerted effort be made to improve the image of the medical profession to the public at large. We know of the appreciation and respect of individual patients for their own physicians and the care that they receive.

A good number of physicians are involved in community service and are generous with their time and money. This should be further and strongly encouraged. Physicians have leadership capacity and can provide a role model of inspiration and commitment. They can and should demonstrate visibly an involvement in public and community service. Public health and public education have been areas of tremendous contributions by physicians. It is important, however, that we participate in community affairs, civic groups, and volunteer organizations. We also need more participation and monetary contributions to fund-raising and charity events. Furthermore, in medically oriented fund-raisers in Maryland, such as for Health Care for the Homeless or the Domestic Violence Center, Med Chi should be represented and offer the support and assistance of the organization.

No one disputes the countless hours of free care to the poor and needy provided by a good number of physicians. The demands of medical practice often do not allow for much free time. The public has to see, however, more of the altruism and generosity of the physician outside the office and the hospital.

Some of you already may be involved in special community and charity projects. Please let us know so that we can provide publicity through the media whenever possible.

The Public Relations Committee of the Medical and Chirurgical Faculty of Maryland



Kent County's name a matter of timing

I would like to thank Dr. Gershen for his interesting article "Maryland! My Maryland!" in the March 1994 issue.¹ Most of what he has written I will accept on faith, but there is one correction, or at least a difference of opinion. He states that "Kent County derives its name from Edward Augustus, the Duke of Kent (Queen Victoria's father)."

That is chronologically impossible. Queen Victoria's father, Edward, Duke of Kent, was the fourth son of King George III. George III, Victoria's grandfather, was born in 1738. In contrast, Kent County, Maryland, was officially being described in the Archives of the State as early as August 2, 1642, as the "County of Kent." My references indicate that was the first definite time Kent County was referred to as such.

Concerning the original naming of the county, Tilghman, quoting his ancestor Harrison, writes: "The pre-

cise year is nowhere mentioned, but it is tolerably well established that it must have been in 1628 or 1629 when [Captain William Claiborne of Kent Island] set sail from Jamestown; and after a voyage of which no account is given he established himself upon an island upon the eastern side of the Chesapeake Bay . . . and to which he gave the name of Kent, in honor, it is suggested by one analyst, of the Governor of England, who was a native of the county of that name in England."

Again—thank you for your articles. You can write and create; I can only criticize what the creative spirits achieve.

CHRISTIAN E. JENSEN, M.D.
Denton, Maryland

Reference

1. Gershen B. "Maryland! My Maryland!" *Md Med J* 1994;43:275-277. ■

Dr. Gershen replies

You are indeed absolutely correct. The name was derived from Kent County, England, and not from Edward Augustus, Duke of Kent.

The reference I employed was *The Illustrated Dictionary of Place Names* edited by Kelsie B. Harder (Van Nostrand Reinhold, 1976). On page 271, the author discusses United States and Canadian names attributable to Edward Augustus and concludes that Kent County, *Delaware*; Kent County, *Maryland*; Kent County, *New Brunswick*; Kent County, *Rhode Island*; as well as *Kentville, Nova Scotia*

and *New Kent* and *New Kent County, Virginia*, may all have originated in this manner. However, the author does provide a caveat, which I confess I ignored. He explains that some of these "names may be for the *county in England* from which the title is taken." Unfortunately, I overlooked that caution in my research.

I cherish accuracy and am indebted to you for advising me of a flagrant error.

Most especially, I am always pleased to discover I have a reader.

BARTON J. GERSHEN, M.D.
Rockville, Maryland ■



Regarding the Uniformed Services University of the Health Sciences

The feature article in the June 1994 issue of *Maryland Medical Journal* described the special attributes of Maryland's third medical school, the Uniformed Services University of the Health Sciences.¹ A different kind of service academy, the F. Edward Hébert School of Medicine prepares its graduates for special family practices composed of members of the armed forces.

This school has frequently been a target of Congressional budget analysts who believe that physicians can be trained in any civilian medical school and recruited to the military at a lesser cost to the nation. USUHS, however, adds a "priceless ingredient" to the medical education of each graduate: an intimate working knowledge of the service of the graduate's choice. Hrehorovich and Seaby described well how students receive special introductions to "family cultures" of the services, sets of special needs, and many unique risks of the military with which USUHS physicians must be familiar. While in medical school, they experience at first hand many of the different environments in which troops may work

and fight and where they, as medical officers, will provide expert medical care.

Many USUHS graduates have come from the working services, occasionally from one of their own academies, and they return to them better trained for a professional life than if they had come fresh to the military from civilian backgrounds.

USUHS, the Hébert school, indeed warrants the recognition given by Med Chi and the *MMJ*'s editors. It also deserves continued national support, especially that of Maryland's Congressional delegation, if our nation is to retain its international pre-eminence.

JOHN B. DE HOFF, M.D.
Baltimore, Maryland

Reference

1. Hrehorovich VR, Seaby RM. Nancy E. Gary, M.D.,: Dean, F. Edward Hébert School of Medicine, Uniformed Services University of the Health Sciences. *Md Med J* 1994;43:501-504. ■

LETTERS To The Editor

The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

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The AMA has created a toll-free hotline offering physicians daily, up-to-the-minute updates on the status of health system reform in Congress.

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Physicians and their families are encouraged to contact their senators and representatives to seek support for organized medicine.

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Suburban Hospital: 50 years of service to the community

Brian G. Grissler and Eugene P. Libre, M.D.

Mr. Grissler is president and chief executive officer of Suburban Hospital in Bethesda, Maryland. Dr. Libre, a hematologist and medical oncologist, is co-director of the hospital's department of medical education.

Suburban Hospital was established during World War II to meet the needs of the rapidly expanding population of Montgomery County, Maryland. With barracks-like patient rooms, 100 beds, and plenty of community volunteers, Suburban Hospital admitted its first patients on December 13, 1943.

Fifty years later, one finds an architecturally different hospital fundamentally meeting its original mission. Suburban Hospital is a community-owned, not-for-profit organization dedicated to maintaining and improving the physical and mental health status of the citizens of Montgomery County and northwest Washington, DC. It is a 388-bed, state-of-the-art medical and surgical facility supported by volunteers and the community in much the same manner as it was in 1943.



From its inception, Suburban Hospital has served the needs of the people of Montgomery County.



Today, Suburban Hospital is an up-to-date medical center still dedicated to its original mission of community service.

The emphasis on community involvement came early for Suburban Hospital. Community members conducted door-to-door fund-raising drives to help pay for the original building. In 1950, community leaders were confronted with the choice of either losing the hospital or purchasing it from the government for \$125,000. Choosing the latter, they created The Suburban Hospital Association, which immediately initiated an expansion program. The board of trustees volunteered to ask six local banks to lend \$20,000 each to the association to make the purchase. The Suburban Bank, Hamilton National Bank, Munsey Trust Co., Riggs National Bank, Liberty National Bank, and the National Savings Trust Company cooperated in making the funds available, and the community will always be grateful to them.

Six years later, an ambitious, ten-year expansion project began. Between 1956 and 1966, three new wings were added, as well as the hospital's first intensive care unit, a 17-bed facility that included an 11-bed cardiac care unit.

In 1976, Suburban Hospital became the first designated regional shock trauma center in Maryland. Working with the University of Maryland and the Washington Hospital Center, Suburban Hospital helps ensure that patients receive the specialized trauma care they need.

A medical library and expanded, progressive, intensive and coronary care units were added to the list of services provided at Suburban Hospital. The expansion plan also included a cardiac angiographic laboratory; the Mary Esther Center for Women, a facility dedicated to diagnostic imaging for women; and a diabetes education program for the community.

In 1991, the hospital launched its Commitment to Excellence Capital Campaign, which resulted in the opening of two new clinical departments, the Eugene B. Casey Center for Diagnostic Cardiology and the Radiation Oncology Center. As part of Suburban Hospital's cancer program, the clinical oncology center, a 23-bed inpatient unit and a 3-bed outpatient treatment room, also was opened. The cancer program has an affiliation with The Johns Hopkins University.

Other excellent clinical programs are a comprehensive orthopedic center, an inpatient and outpatient addiction treatment center, and a 24-bed psychiatric unit. In 1993, an elevated helipad with direct access to the shock trauma center, as well as a state-of-the-art underground auditorium and conference rooms were dedicated.

As Suburban Hospital faces the challenges of health care reform, the board of trustees, together with the medical staff, employees, and management team, will focus on five crucial areas: expanded ambulatory services, integrated continuums of care, organized physician and hospital collaboration, continuous quality improvement, and regional networking and affiliations.

Through the efforts of our medical staff, employees, volunteers, and board of trustees, the hospital will strive to meet the needs of our community by providing a comprehensive range of high quality, compassionate, cost-effective services. The articles in this issue of the *Maryland Medical Journal* recognize and underscore Suburban Hospital's commitment to the community. Suburban Hospital wishes to thank all those who contributed to the success of its first 50 years. ■

Pleomorphic carcinoma (spindle and giant cell) of the lung

Ira P. Krefting, M.D., L. Alberto Nunez, M.D., Peter Sherer, M.D., Alan Weinstock, M.D.,
Aruna Kumar, M.D., and William Travis, M.D.

*Dr. Krefting is a pulmonary specialist,
Dr. Nunez is a thoracic surgeon,
Dr. Sherer is an oncologist, Dr.
Weinstock is an internist, Dr. Kumar is
a pathologist, and Dr. Travis is a
pulmonary pathologist at Armed
Forces Institute of Pathology.
All practice in Montgomery
County, Maryland.*

ABSTRACT: *Pleomorphic carcinoma is a rare, very aggressive subtype of lung cancer that follows the clinical pattern of carcinosarcoma. The tumors tend to present as a peripheral mass frequently showing a mixture of spindle and giant cell features and often are associated with other, more common histologic subtypes of lung carcinoma. Clinical outcome is poor, with median survival of ten months. This article describes an unusual lung tumor (pleomorphic carcinoma) in a patient presenting with explosive symptoms suggesting an infection.*

Case history

A 42-year-old professor of architecture presented as an outpatient for evaluation of hemoptysis. He was a Native American who had grown up in the Hudson Bay area of Canada. He had a history of a positive tuberculin test and increasing lethargy. The posterior-anterior and lateral chest x-ray showed a right upper lobe infiltrate (**Figure 1**). Sputum cultures were obtained and antituberculosis therapy was initiated with isoniazid, rifampin, and pyridoxine.



Figure 1. Chest x-ray at the time of presentation showing right upper lobe infiltrate.

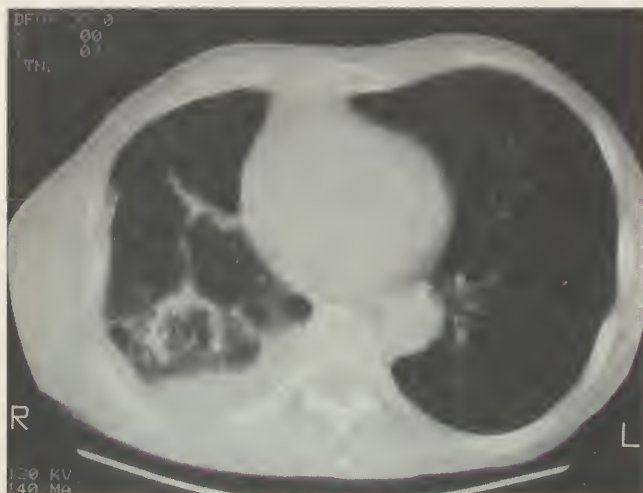


Figure 2. Computerized axial tomographic scan demonstrating right upper lobe infiltrate and peripheral tumor mass.

In December 1988, the patient was hospitalized for further evaluation of continuing hemoptysis. Computerized axial tomography of the chest suggested a possible mass (**Figure 2**) and the patient underwent both rigid and fiberoptic bronchoscopy. Bleeding from the right upper lobe was noted, but no diagnosis could be made. Brisk hemoptysis persisted. A thoracotomy performed in January 1989 showed a tumor mass; the postoperative course was complicated by sepsis.

After gradual improvement, the patient was started on a course of doxorubicin hydrochloride and cyclophosphamide therapy, as well as radiation therapy. He was then lost to follow-up for approximately three months. When he returned, he had lost 30 pounds and was using a cane. His sputum cultures remained negative for tuberculosis and fungal organisms.

The patient was rehospitalized. Candidal esophagitis and gastritis were diagnosed, as well as distal peripheral neuropathy and L2-L3 radiculopathy (which explained his use of the cane). Bilateral perinephric masses were detected and drained (**Figure 3**). Percutaneous drainage showed spindle cells with marked degenerative changes suggesting necrotic tumor. The patient's clinical state continued to deteriorate and he died in July 1989. No autopsy was performed.

Pathologic features. The lung specimen obtained at thoracotomy showed the right upper lobe measured 15 x 13 x 13 cm. Within the upper portion was a 3 cm hemorrhagic and cystic mass surrounded by extensive areas of yellow consolidation. The overlying pleural surface was thickened.

Histologic features. Most of the tumor consisted of atypical spindle cells growing in sheets or in a storiform pattern (**Figure 4**). The nuclei were slender and hyperchromatic with dense chromatin. There were frequent mitotic features. Giant cells were scattered singly and in small clusters (**Figure 5**). In one region, the tumor showed prominent epithelial features with focal glandular elements consistent with poorly differentiated adenocarcinoma (**Figure 6**).



Figure 3. Computerized axial tomographic scan section of abdomen with perinephric mass.

Immunohistochemical staining of the spindle cell component was focally positive for epithelial membrane antigen and indicated spindle cell carcinoma (**Figure 7**). Stains for S-100 protein, desmin, and vimentin were negative. Keratin staining was not satisfactory.

Discussion

The tumor was remarkable for the mixture of spindle cell carcinoma, giant cell carcinoma, and adenocarcinoma; however, classification of the tumor raises several questions. Although spindle cell carcinomas have been classified by the World Health Organization (WHO) as a variant of squamous cell carcinoma,¹ the tumor described above showed features of adenocarcinoma rather than squamous cell carcinoma. In recent years, it has been recognized that a variant of histologic subtypes other than squamous cell carcinoma can be associated with spindle cell carcinoma, including adenocarcinoma and

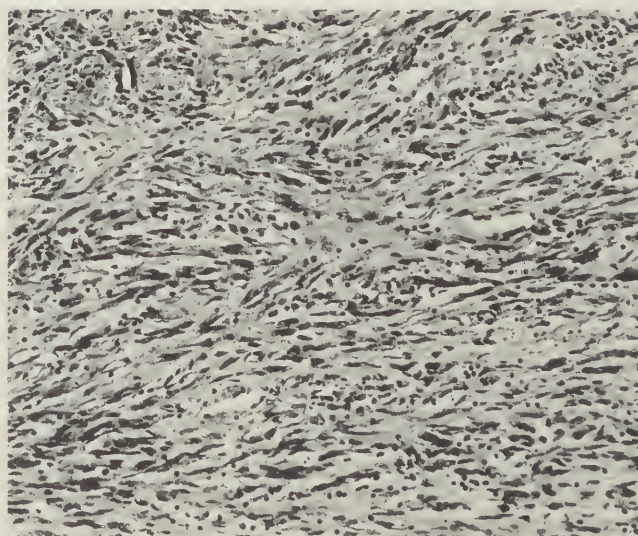


Figure 4. Spindle-shaped cells growing in sheet-like pattern show hyperchromatic nuclei (hematoxylin and eosin x 200).

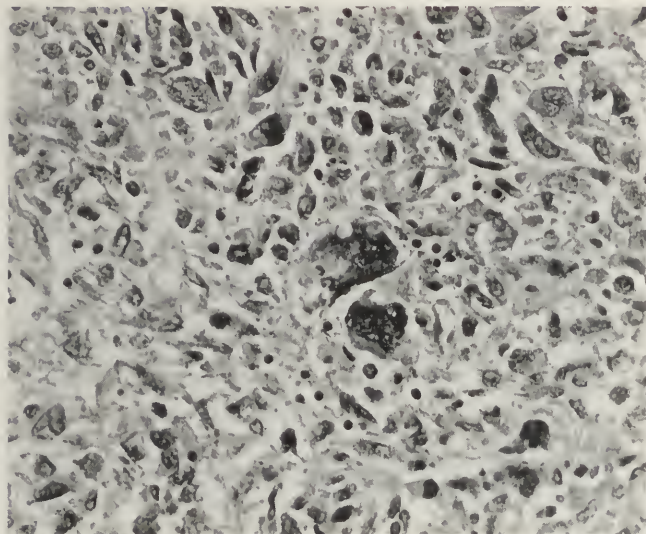


Figure 5. Several giant tumor cells (center) show large hyperchromatic nuclei and a high nuclear to cytoplasmic ratio. The surrounding cells have an epithelial appearance with a round to oval shape and ample cytoplasm (hematoxylin and eosin x 200).

small cell carcinoma.²⁻⁵ In addition, the separation of spindle cell carcinoma from carcinosarcoma is somewhat controversial and carcinosarcoma is included in the differential diagnosis of this tumor.

In a recent study of 78 cases of spindle cell and giant cell carcinomas of the lung, Fishback and colleagues⁶ reported that histologic patterns of spindle cell and giant cell carcinoma coexist in 40% of cases. Scattered giant cells also were present in the tumor described herein. Fishback et al also found that these tumors were frequently associated with other common histologic subtypes of lung carcinoma, particularly adenocarcinoma, large cell carcinoma, squamous cell carcinoma, and small cell carcinoma. Both spindle cell and giant

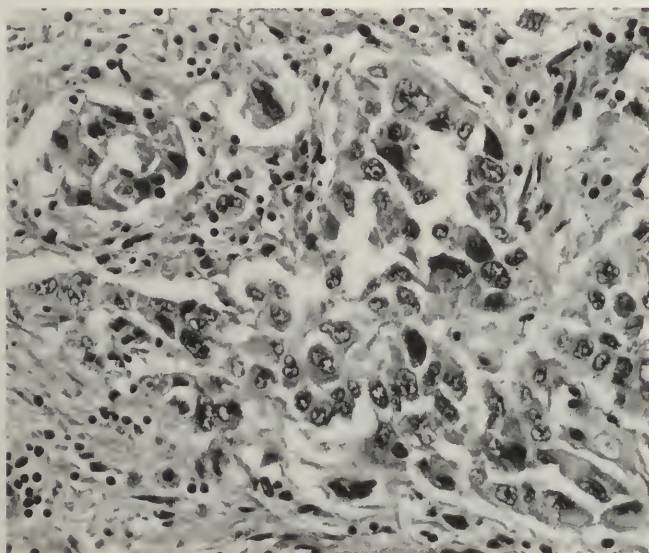


Figure 6. Epithelial cells are growing in a gland-like fashion showing adenocarcinomatous differentiation (hematoxylin and eosin x 400).

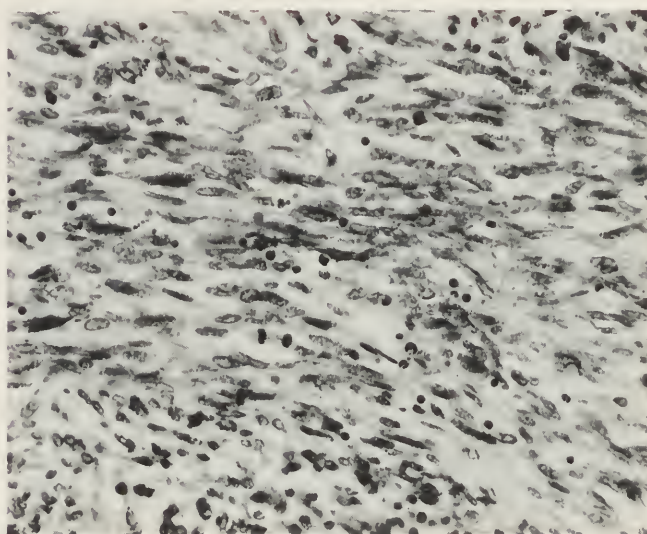


Figure 7. Epithelial membrane antigen positively stains the spindle-shaped tumor cells (epithelial membrane antigen x 400).

cell carcinomas were frequently peripheral in location, were at an advanced stage, and had a poor prognosis (five-year survival rate of 10% and a median survival of ten months).⁶ There was no difference in survival based on the associated histologic subtypes (i.e., squamous vs adenocarcinoma).

Based on these observations, the term *pleomorphic carcinoma* was proposed for lung carcinoma showing spindle and/or giant cell features. Because large cell carcinoma is often peripheral in location and has a similarly poor five-year survival rate (11%),⁷ it was suggested that pleomorphic (spindle/giant cell) carcinoma should be grouped with large cell carcinoma rather than squamous cell carcinoma.⁶ The patient described herein had a poor prognosis (widespread metastasis and death within eight months).

A biphasic tumor with malignant epithelial and spindle cell components also raises the question of a carcinosarcoma.^{8,9} According to the WHO, carcinosarcomas consist of tumors composed of two elements: carcinoma and sarcoma.¹ If the sarcoma exhibits malignant cartilage, bone, or skeletal muscle, it is easy to be certain of the sarcomatous differentiation. If heterologous components are lacking, however, separation from spindle cell carcinoma can be difficult. It has been suggested that if epithelial differentiation cannot be demonstrated in the spindle cell component of a biphasic tumor by immunohistochemistry and/or electron microscopy, the diagnosis of carcinosarcoma could be made.¹⁰ This point is controversial because other investigators have classified such tumors as sarcomatoid or spindle cell carcinoma.^{3,4} In the case described herein, although spindle cells stained only focally for epithelial membrane antigen, this finding suggested that this component was carcinomatous rather than sarcomatous.

It has been suggested that there may be a continuum of differentiation from spindle cell carcinoma to sarcoma and that the separation of carcinosarcoma from spindle cell carcinoma may be arbitrary and of little clinical significance.¹⁰ Because both tumors are rare and few studies are large enough to determine survival, additional work is needed to determine if there are significant differences in survival or clinical behavior. Carcinosarcomas and sarcomas account for 0.1% of all lung malignancies, compared to 0.3% for spindle cell/giant cell carcinomas.⁷

In summary, this case represents an example of pleomorphic (spindle/giant cell) carcinoma of the lung. If a lung malignancy demonstrates spindle or giant cell features, the diagnosis of pleomorphic carcinoma should be considered.

References

1. World Health Organization. *Histological Typing of Lung Tumors*. Geneva, Switzerland: World Health Organization; 1981.
2. Tsubota YT, Kamaguchi T, Hono T, Nishino E, Travis WD. A combined small cell and spindle cell carcinoma of the lung: report of a unique case with immunohistochemical and ultrastructural studies. *Am J Surg Pathol* 1992;16:1108-1115.
3. Ro JY, Chen JL, Lee JS, Sahin AA., Ordonez NG, Ayala AG. Sarcomatoid carcinoma of the lung. Immunohistochemical and ultrastructural studies of 14 cases. *Cancer* 1992;69:376-386.
4. Matsui K, Kitagawaa M, Miwa A. Lung carcinoma with spindle cell components: 16 cases examined by immunohistochemistry. *Hum Pathol* 1992;23:1289-1297.
5. Cagle PT, Alpert LS, Carmona PA. Peripheral biphasic adenocarcinoma of the lung: light microscopic and immunohistochemical findings. *Hum Pathol* 1992;23:197-200.
6. Fishback NF, Kos MN, Travis WD, Moran CA, McCarthy W. Pleomorphic (spindle and giant cell) carcinomas of the lung. A clinical pathologic study of 78 cases. *Mod Pathol* 1993;6:130.
7. Travis WD, Travis LB, Devesa SS. Lung cancer incidence and survival by histologic type. *Cancer* in press.
8. Engel AF, Grote G, Bellot S. Carcinoma of the lung: a case history of disseminated disease and review of the literature. *Eur J Surg Oncol* 1991;17:94-96.
9. Summermann HH, Seitz G. Carcinosarcoma of the lung: a tumor which has a poor prognosis and is extremely rarely diagnosed preoperatively. *Thorac Cardiovasc Surg* 1990;30:247-250.
10. Humphrey PA, Scroggs MW, Roggeli VL, Shelburne JD. Pulmonary carcinomas with a sarcomatoid element: an immunocytochemical and ultrastructural analysis. *Hum Pathol* 1988;19:155-165. ■

Med Chi Bicentennial Celebrations

*Med Chi has already begun planning celebration activities for its bicentennial in 1999.
If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at
410-539-0872 or 1-800-492-1056.*

Transesophageal echocardiography

Mark Milner, M.D.

Dr. Milner, a practicing cardiologist and clinical professor of medicine at George Washington and Georgetown University medical centers, is director of the transesophageal and echocardiography laboratory at Suburban Hospital in Bethesda, Maryland.

ABSTRACT: *During the past ten years, two-dimensional echocardiography has become a major tool in the assessment of cardiovascular diseases. With the advent of pulsed, continuous wave, and color flow Doppler, the field of echocardiography is now accepted as the ideal noninvasive technique for assessing left and right ventricular function; determining valvular stenosis or regurgitation; assessing pericardial disease (i.e., constrictive pericarditis, pericardial effusion); determining diastolic dysfunction; estimating pulmonary artery pressures; examining for cardiac source of emboli; and evaluating for endocarditis. During the past five years, semi-invasive applications have included intracardiac echocardiography, guiding pericardiocentesis, assisting in percutaneous mitral valvotomy, catheter placement for ablation procedures, optimizing pacemaker hemodynamics, and using contrast agents to assess myocardial viability. With the miniaturization of transducers, bioengineers have developed probes small enough to be incorporated into the tip of a flexible gastroscope, thus accelerating the development of one of the most exciting and innovative techniques in cardiology, transesophageal echocardiography.*

Routine transthoracic imaging sometimes may be unsatisfactory because of multiple acoustic barriers, including thoracic (air, bone, subcutaneous tissue) and cardiac (calcification, mechanical valves) impediments. Using the esophagus as an imaging window, transesophageal echocardiography (TEE) allows ultrasonic imaging of the cardiac and pericardiac structures by circumventing chest wall interference and thoracic attenuation of sound waves. From this retrothoracic imaging plane, the echocardiography probe is in juxtaposition with the left atrium and the thoracic aorta, allowing

multiple cross-sectional views of the cardiac structures that only rarely are obtainable from routine transthoracic imaging.

Equipment

The concept of using the esophagus as an ultrasonic imaging window to the heart was introduced in 1976. Initial attempts, feasible only in anesthetized patients because of the need for a rigid shaft, were limited to a very small field of view (4 cm by 4 cm). In 1980, miniaturized probes using phased-array technology were incorporated at the end of a flexible endoscope housing. The modern-day transesophageal probe uses a modified-flexible endoscope with one or two (biplane imaging-two orthogonal imaging planes) phased-array transducers (3.5-7.5 mHz, 32-64 elements). More recently, probes have incorporated a rotatable transducer, allowing full panoramic planar imaging.

The shaft of the adult probe is approximately 9 mm in diameter (6 mm for pediatric patients) and the tip ranges from 10 mm to 13 mm in diameter. Two control knobs allow 90-degree forward and reverse mobility and approximately 70 degrees of lateral mobility.

Technique

The patient is allowed nothing by mouth for four to six hours. A brief history of any dysphagia or esophageal disease is obtained. Topical lidocaine is used for local anesthesia. Several institutions routinely use a drying agent such as glycopyrrolate to reduce secretions. In anxious or young patients, intravenous diazepam or midazolam, with or without meperidine, is often used for sedation. Antibiotic prophylaxis for endocarditis is controversial and usually is reserved for patients with valve prostheses. Insertion of the transducer is similar to that for performing endoscopy, with patients maintained on their left side to prevent aspiration. Following esophageal intubation, images of the cardiac structures and thoracic aorta are obtained from both the stomach and the esophagus. The examination usually can be completed in five to ten minutes. Throughout the procedure, vital signs, single-lead electrocardiography, and pulse oximetry are monitored continuously.

Clinical applications

Because of the proximity of the heart to the esophagus and the absence of interfering structures (e.g., lung, bone), transesophageal images are clearer than those produced by routine echocardiography. Thus, one of the common indications for TEE is in patients with technically inadequate transthoracic echocardiographic images (e.g. obese or emphysematous patients), or in patients with recent chest trauma or chest surgery. In addition, TEE provides a unique view of the posterior cardiac structures such as the atria and their appendages, the pulmonary veins, and the descending thoracic aorta.

Cardiac emboli. The most common indication for outpatient TEE is detection of an intracardiac source of embolism. In one

study of 153 subjects with unexplained arterial emboli (normal carotid anatomy), there was an almost twofold increase (58% vs 36%) in the detection of potential cardiac embolic sources, particularly in the examination of the left atrial appendage, the most common site for cardiac thrombi.¹ With routine echocardiography, the atrial appendage is rarely seen, but with TEE it is easily identified in almost all patients. The higher resolution obtained with TEE allows detection not only of intracardiac thrombi as small as 1 to 2 mm, but of spontaneous echo contrast (SEC). SEC is rarely seen on routine echocardiography, but is common in subjects at increased risk for embolic events (e.g., mitral stenosis). SEC is believed to represent sludging of red cells or platelet aggregates and thus a prethrombotic state. Other potential causes of cardiac emboli that are better seen using TEE than other noninvasive techniques include myxomas or other tumors, atrial septal aneurysms, valvular vegetations, myxomatous mitral valve disease, patent foramen ovale or atrial septal defect, or mobile plaque in the ascending aorta.

Valvular pathology. TEE is the optimal method for assessing valvular incompetence, especially mitral regurgitation. Because of its retrograde location, the TEE probe allows superb resolution of the left atrium and pulmonary veins. With color Doppler, the severity of the regurgitation can easily be assessed. By examining pulmonary venous flow patterns, TEE also provides a unique assessment of the hemodynamic consequence of the regurgitant jet on the pulmonary circulation (i.e., pulmonary capillary wedge pressures). It is now considered the standard technique for assessing the need for surgery and the adequacy of surgical results in patients undergoing mitral valve repair.

Aortic dissection. TEE has been reported to be superior to angiography and computed tomography (CT) in the exclusion of aortic dissection. Its sensitivity and specificity are reported to be near 100%, and it provides important clinical information not routinely obtained with other techniques.² In subjects with aortic dissection, TEE can locate the origin of the intimal entry site or sites, determine the need for aortic valve replacement, assess involvement with arterial branches such as the coronaries, evaluate left ventricular systolic function, and determine if the dissection has extended into the pericardium. In addition to having the best predictive value of all techniques, TEE is less expensive, involves minimal risk for the patient, and can be performed at the bedside in as little as five to ten minutes. At major cardiothoracic medical centers, patients with aortic dissection diagnosed by other techniques often are reassessed by TEE in the operating room to provide further diagnostic information to the surgeon.

Infective endocarditis. In addition to easy detection of native valve endocarditis (sensitivity and specificity greater than 90%),^{3,4} TEE evaluation allows accurate assessment of the size of the vegetation (as small as 2 mm), the presence of multi-valve endocarditis, and the degree of valvular destruction and

secondary re-gurgitation. Probably the greatest benefit of TEE is its ability to detect a paravalvular abscess, a condition that requires surgical treatment: in one study, sensitivity with routine echocardiography was only 28%, whereas with TEE, it was 87%.⁵

Intracardiac or pericardiac tumors. TEE can accurately differentiate intracardiac tumors from extracardiac tumors in juxtaposition to the heart. It provides a fine, detailed analysis of the tumor's location and attachments, in addition to determining if there are satellite tumors. In many cardiac surgery programs, TEE is routinely used in the operating room to help the surgeon choose the optimal approach for surgical excision.

Prosthetic valve dysfunction. Due to the high attenuation of the ultrasound signal by prosthetic devices, the precordial approach often provides a poor acoustic window for assessing prosthetic valve dysfunction, especially mitral prosthetic regurgitation. Because the esophagus is adjacent to the left atrium, the TEE probe can detect and quantify the degree of prosthetic regurgitation, as well as determine whether the leak is valvular (due to prosthetic dysfunction) or perivalvular (due to dehiscence of the suture ring).

Percutaneous balloon mitral valvotomy. TEE has been used successfully in awake patients during percutaneous balloon mitral valvotomy for the treatment of critical mitral stenosis.⁶ This procedure was well tolerated and allowed direct, online visualization of the fossa ovalis and the mitral funnel, thus decreasing the potential for catheter-related complications, shortening the procedure time, and limiting patient and physician exposure to radiation. TEE has significantly reduced procedure-related complications and is likely to be a major tool in future percutaneous cardiac interventional procedures.

Cardiac surgery. Over the past ten years, the approach to valvular surgery has changed from replacing the valve with a prosthesis to trying to repair the native valve. Successful surgical repair is associated with lower in-hospital and long-term mortality, less post-operative myocardial dysfunction, and avoidance of the thrombotic complications associated with prosthetic devices. TEE allows the surgeon to determine whether valvular repair is feasible based on the intrinsic anatomy. It also provides a means for the surgeon to assess the surgical technique during surgery and, if necessary, alter the original repair. In most cardiovascular surgery programs in the United States, intraoperative echocardiographic evaluation is now standard protocol for valvular reparative procedures. TEE also has allowed greatly improved evaluation of surgical results in patients with congenital heart disease.

Intraoperative monitoring. TEE was first used clinically to detect air emboli during neurological surgical procedures. It is now commonly used for intraoperative monitoring for coronary ischemia and for assessing fluid status (left ventricular volume or preload).⁷

Atrial septal defects/patent foramen ovale. TEE is the most sensitive technique for detecting a patent foramen ovale or atrial

septal defect. It can easily determine the size and location of the defect, as well as the presence of any associated congenital anomalies such as anomalous pulmonary venous return. TEE has been used to assist in the percutaneous closure of an atrial septal defect using a catheter-loaded umbrella device, thus avoiding open heart surgery.

Complications

Reports of major complications associated with TEE are extremely rare. No major complications were associated with the first 1,000 procedures performed at the Washington Hospital Center (Goldstein SA, personal communication). Minor complications (sore throat, mild esophageal discomfort, oversedation, gagging) were infrequent. One subject had transient atrial fibrillation. Intubation of the esophagus was unsuccessful in only two of the first 1,000 subjects (0.2%). Rare complications reported by other institutions include cardiac arrhythmias, aspiration, esophageal bleeding, perforation in a patient with undiagnosed esophageal carcinoma, respiratory arrest from excessive intravenous sedation, major hypoxia, and myocardial ischemia.

Summary

TEE, by providing a unique "window" for examining the heart, has become an important cardiac imaging method for a variety of disease states. The procedure is well tolerated and can be done safely by a physician well versed in echocardiography and endoscopy and familiar with the broad spectrum of cardiovascular pathophysiology.

References

1. Hofmann T, Meinertz T. Transesophageal echocardiography in patients with systemic arterial embolism. *Herz* 1993;18:301-317.
2. Erbel R, Engberding R, Daniel W, Roelandt J, Visser C, Rennollet H. Echocardiography in diagnosis of aortic dissection. *Lancet* 1989;1:457-461.
3. Lowry RW, Zoghbi WA, Baker WB, Wray RA, Quinones MA. Clinical impact of transesophageal echocardiography in the diagnosis and management of infective endocarditis. *Am J Cardiol* 1994;73:1089-1091.
4. Shapiro SM, Young E, De Guzman S, Ward J, Chiu CY, Ginzton LE, Bayer AS. Transesophageal echocardiography in diagnosis of infective endocarditis. *Chest* 1994;105:377-382.
5. Daniel WG, Mugge A, Martin RP, Lindert O, Hausmann D, Nonnast-Daniel B, Laas J, Lichtlen PR. Improvement in the diagnosis of abscesses associated with endocarditis by transesophageal echocardiography. *N Engl J Med* 1991;324:795-800.
6. Milner MR, Goldstein SA, Lindsay J, Leon MB, Lee KH, Pichard AD. Transesophageal echocardiographic guidance for percutaneous balloon mitral valvuloplasty. *Circulation* 1990;82:81.
7. Milner MR, Keren G, Goldstein SA, Duran L, Mispireta LA, Lindsay J. Pulmonary venous flow and transmitral flow: effect of varying loading conditions. *J Am Soc Echocardiogr* 1991;4:300.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

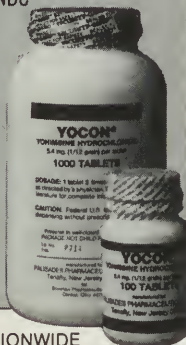
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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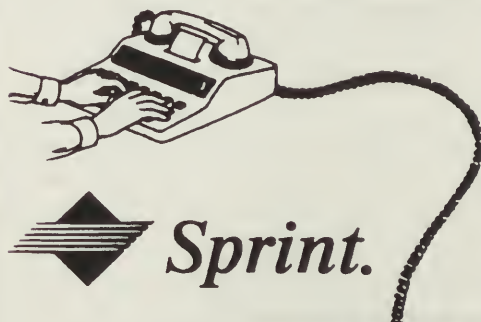
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Thoracic outlet syndrome: the Suburban Hospital experience

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ABSTRACT: Thoracic outlet syndrome (TOS) embodies a constellation of symptoms arising from compression of the nerves, arteries, and veins at the base of the neck. Symptoms may vary in distribution and intensity, depending on which of the three structures in the neurovascular bundle are involved. The majority of patients benefit from nonsurgical management; however, when surgery is indicated, transaxillary first rib resection has a high degree of acceptance from patients and surgeons. Length of hospital stay for surgery is brief and long-term results appear to be excellent. This article reviews the fundamentals of recognition and management of TOS and describes recent Suburban Hospital experience.

There are a variety of acute and chronic disorders of the base of the neck and upper extremities that produce pain and disability. Initial presentation may be to the primary care physician. A variety of surgical and nonsurgical specialists may then be consulted for the symptoms. A myriad of terms have been used in various specialties confronting these often confusing symptoms. **Table 1** lists many of the common terms included under the description thoracic outlet syndrome (TOS).

Overview

Anatomic structure. The thoracic outlet can be visualized as an anatomic triangle with the nerves of the brachial plexus entering the triangle from the cervical spine and the subclavian artery from the chest. The subclavian vein enters the triangle from the arm. The floor of the triangle is the first rib. The lateral side of the triangle is the scalenus medius muscle and the medial border is the scalenus anticus. The subclavian vein lies outside the triangle medially and is bordered by the clavicle and the manubrium. The clavicle

Table 1. Common terms included in thoracic outlet syndrome¹

- ☐ Adson's syndrome
- ☐ brachial plexus syndrome
- ☐ cervical brachial compression syndrome
- ☐ cervical rib syndrome
- ☐ cervicobrachial neurovascular compression syndrome
- ☐ costoclavicular syndrome
- ☐ effort vein thrombosis syndrome
- ☐ first thoracic rib syndrome
- ☐ fractured clavicle syndrome
- ☐ humeral head syndrome
- ☐ hyperabduction syndrome
- ☐ Paget-Schrotter syndrome
- ☐ pectoralis minor syndrome
- ☐ pneumatic hammer syndrome
- ☐ rucksack paralysis
- ☐ scalenus anticus syndrome
- ☐ shoulder-arm syndrome
- ☐ shoulder-girdle syndrome

and subclavius muscle form a bridge overlying these triangles (Figure 1).

Ribs are usually associated with only the thoracic vertebrae T1 - T12. If a C8 rib, bony exostosis fracture callus of the clavicle, or congenital ligamentous bands enter these triangles, the likelihood of pathologic compression and clinical symptoms increases. Excessive muscular development (e.g., due to weight lifting) or abnormal muscular relationships (e.g., due to poor posture) increase the likelihood that the normal anatomic relationships will result in symptomatic compression (Figure 1).

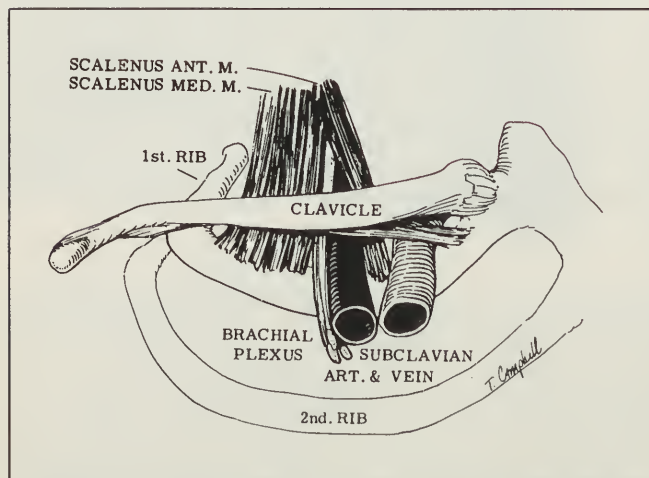


Figure 1. From Kelly¹; reproduced with permission from J.B. Lippincott Company.

Symptoms. Neurologic symptoms are the most common, followed by venous symptoms and then arterial symptoms² (Figure 2). Thoracic outlet compression rarely produces symptoms of more than one anatomic structure (i.e., artery and vein, nerve and artery, etc). Neurologic symptoms due to compression of the brachial plexus are most common and consist of pain, paresthesia, and paresis. In contrast, symptoms of cervical disk disease or carpal tunnel syndrome are usually more constant in nature.³

Women are afflicted more often than men. Pain may occur in the neck, shoulder, occipital region, and arm and hand, especially in the ulnar distribution (fourth and fifth fingers). Pain may be mild to excruciating. Symptoms may be migratory, given the muscle spasm component that may attend these relationships. Numbness and paresthesia in the hand also may coexist, most commonly in the ulnar distribution. Weakness is uncommon, but may occur more frequently in posttraumatic or cervical rib anomalies or compression of longstanding duration. Paresis develops gradu-

ally. The symptoms may be exacerbated by repetitive movement such as typing, writing, or playing musical instruments. Any of the symptoms may be positional, such as driving a car or combing hair.

Venous compression may result in swelling, heaviness, fatigue, cyanosis, aching, and a tingling sensation associated with swelling following repetitive movements. Thrombosis of the axillary vein (Paget-Schrotter syndrome or effort thrombosis) results in acute venous hypertension manifested by pain, swelling, and discoloration.

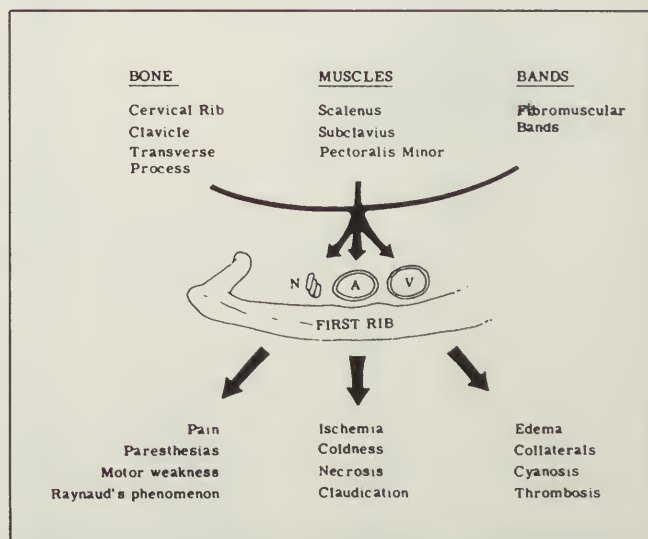


Figure 2. From Kelly¹; reproduced with permission from J.B. Lippincott Company.

Arterial symptoms are rare and occur in less than 1% of all thoracic outlet patients. They include exercise intolerance, constant pain, or fatigue with repetitive exercise. Cold sensation and cyanosis also may be present. In extreme cases, digital emboli, tissue necrosis, ischemic rest pain, or gangrene may be present. Compression of the subclavian artery over the rib may produce turbulent flow resulting in arterial aneurysms in this area.

Diagnosis. Thorough examination of the neck, shoulders, chest, axilla, and upper extremities is essential. Tenderness in the supraclavicular fossa is the most consistent physical finding in TOS. Numbness and weakness in the hand and weakness in adduction and extension in the fourth and fifth fingers may reflect a lower brachial plexus compromise (ulnar/C8/T1). Atrophy of interosseus muscles also may be present.²

A three-minute arm stress test, in which the patient repeatedly opens and closes the fists with arms abducted and externally rotated and forearms flexed (military surrender position), may help to quantify exercise intolerance. If the symptoms of weakness, fatigue, or numbness are reproduced, the test is considered positive for neurologic compression. Vascular compromise can produce pain, weakness, pallor, or swelling with this test.

Adson's maneuver, in which the patient takes a deep breath and elevates the chin towards the affected side, was formerly thought to aid in the diagnosis of TOS. Numerous studies, however, have found that pulse obliteration during the maneuver occurs in a large percentage of normal individuals.^{2,4,5}

Fingertip ulcers, unilateral Raynaud's phenomenon, and evidence of embolization or a pulsatile mass should cause great concern. Arm swelling and abnormal venous collateral patterns around the shoulder girdle are signs of venous compromise. A supra- or subclavicular bruit at rest, although not diagnostic, may be due to arterial pathology, especially if associated with other signs and symptoms of TOS.⁵

Diagnostic tests are generally disappointing in confirming the diagnosis of TOS. A repeated, careful history and physical examination are often the most reliable methods of establishing the diagnosis. Plain x-ray visualization of a cervical rib, elongated C8 transverse process, or fracture callus of the clavicle in a patient with symptoms is essentially confirmatory. Arterial ultrasound, venous duplex scanning, and other vascular laboratory evaluations generally are unrewarding except in clinically obvious vascular problems.

Nerve conduction study findings are inconsistent. When abnormal, they may assist in separating neurologic deficits due to TOS from those due to carpal tunnel problems, but normal findings may be misleading.²

Subclavian arteriograms should be reserved for patients in whom arterial pathology such as aneurysm, stenosis, or

Table 2. Differential diagnosis of thoracic outlet syndrome¹

- ☐ angina
- ☐ arthritis
- ☐ bursitis
- ☐ carpal tunnel syndrome
- ☐ cervical disc
- ☐ cervical spondylosis
- ☐ fibrositis
- ☐ multiple sclerosis
- ☐ myositis
- ☐ neuritis
- ☐ psychoneurosis
- ☐ Raynaud's disease
- ☐ spinal cord neoplasm
- ☐ superior pulmonary sulcus (Pancoast's) tumor
- ☐ tendinitis

embolization is suspected. Venography may be helpful in establishing venous pathology in patients without overt physical findings but with a history of intermittent swelling. Venous occlusion or stenosis at rest or with special maneuvers may elucidate the cause for otherwise-confusing unilateral upper extremity edema. **Table 2** lists the differential diagnosis for TOS. **Table 3** compares TOS, cervical disk disease, and carpal tunnel syndrome.

Treatment. Nonsurgical management helps 50% to 90% of patients with neurologic symptoms of TOS.^{2,3,5,6} Physical therapy, consisting of good posture and very specific shoulder girdle strengthening exercises, is frequently curative.³

A high index of suspicion for venous occlusion is necessary, because it can become chronically disabling if left untreated. Thrombolytic therapy for acute venous thrombosis followed by first rib resection has produced dramatic results. The acute symptom complex may appear very similar to musculoskeletal disorders.⁶ Spontaneous thrombosis of the subclavian vein is not usually associated with underlying clotting disorders; however, it does represent a potential source of emboli. Heparin and warfarin are probably indicated.

Early surgery is indicated for patients with clearly vascular compromise (arterial or venous) or in patients with fixed neurologic deficit. Surgical management for nonarterial TOS consists of resection of the first rib and, if present, the cervical rib. Removal of the rib releases the scalene muscles, divides attached ligamentous bands, and widens the outlet for the neurovascular bundle (**Figure 3**). The

Table 3. Thoracic outlet, cervical disk, and carpal tunnel syndromes

| | <u>Thoracic outlet</u> | <u>Cervical disk</u> | <u>Carpal tunnel</u> |
|--|---|---|---|
| □ Symptoms | | | |
| <i>Pain</i> | Intermittent: neck, shoulder, arm (chest) | Constant: neck, rhomboid, suprascapular | Intermittent: volar wrist, forearm, 1st-3rd fingers |
| <i>Numbness</i> | Intermittent: ulnar nerve area, 4th & 5th fingers, entire arm & hand | Constant: radial nerve distribution, forearm, 1st & 2nd fingers | Intermittent: median nerve distribution; palm, 1st-3rd fingers |
| <i>Weakness</i> | grasp, 4th & 5th fingers, adduction & extension, entire arm & hand | biceps, triceps, deltoid, wrist extension | grasp, pinch, thenar muscles |
| <i>Swelling</i> | none, intermittent, or constant in fingers, hand, or arm | none | occasional, intermittent |
| <i>Aggravation</i> | arm elevation, lifting, reaching, turning head | turning neck, lifting, coughing, straining | sustained grasp, pinch, wrist flexion |
| □ Signs | | | |
| <i>Percussion</i> | tender brachial plexus | tender midline and paracervical | positive Tinel test, volar wrist |
| <i>Compression</i> | tender brachial plexus | neck pain with cervical compression | median nerve symptoms with wrist compression |
| <i>Symptom induction</i> | 3-min. elevated arm stress test; brachial plexus compression | turning, tilting head; cranial compression | Phalen test (1-min. wrist flexion) |
| <i>EMG* & nerve conduction</i> | usually normal, seldom indicated | usually normal | often normal, may show delay at wrist |
| <i>Radiography</i> | usually normal; may show cervical rib, long C7 transverse process; may need phlebogram, arteriogram | degenerative arthritis, narrowed disks, myelogram positive in 85% | usually normal; may show arthritis in hand |
| □ Treatment | | | |
| <i>Nonsurgical</i> | Avoid arm elevation, hunch shoulders, heat, massage, muscle relaxants, analgesics | cervical collar, home traction, analgesics | minimize grasp & pinch; wrist splint, steroid injection, antiinflammatory drugs |
| <i>Surgical</i> | resect first rib & anomalous bands for C8-T1 symptoms; total anterior scalenectomy for C5, C6, C7 symptoms | disectomy (fusion) | resect transverse carpal ligament |

* EMG = electromyography

Adapted from Roos⁴; reprinted with permission

procedure usually can be accomplished from a transaxillary approach under general anesthesia (**Figure 4**), although a supraclavicular approach also may be used. Patients are hospitalized for two to four days and may return to nonstrenuous physical activity in one week. Thoracotomy is usually unnecessary and clavicle resection is rarely indicated. Arterial pathology may require more extensive surgical procedures involving combined supra- and subclavicular approaches.

Results of first rib resection for TOS are generally very good: 70% to 85% of patients report excellent results; 10% to 15%, fair to good results; and 5% to 10%, poor results.² Perioperative complications are few and usually consist of transient pulmonary problems including pneumothorax. Most often, the pneumothorax may be treated expectantly; chest tubes are

needed only infrequently. Long-term complications (e.g., recurrence, missed pathology, postoperative pain syndromes) are rare.

Retrospective chart review of TOS at Suburban Hospital

Records of patients treated by first rib resection at Suburban Hospital for TOS from January 1, 1980, to February 28, 1994, were reviewed. There were seven women and five men ranging in age from 15 to 60 (average age, 36).

There were five right first rib resections and seven left first rib resections. Of the seven patients in whom the dominant extremity was clear, surgery for the dominant extremity was performed in only two patients.

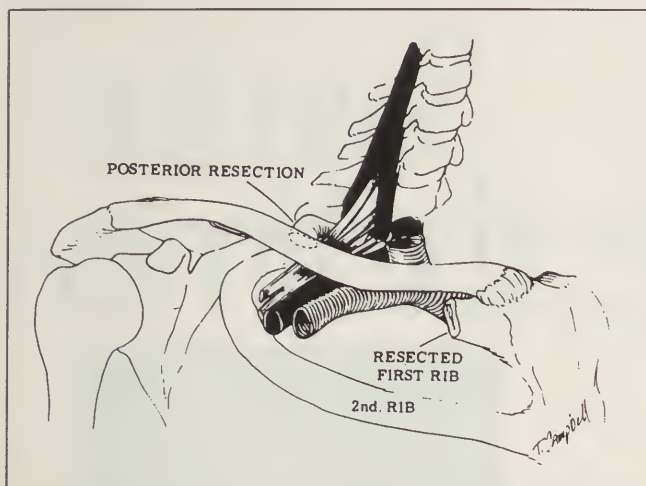


Figure 3. From Kelly¹; reproduced with permission from J.B. Lippincott Company.

Four patients had a prior history of blunt trauma without a resulting fracture. One patient had nonocclusive venous compromise that began after initiation of rowing machine use as part of a vigorous exercise program. No occupational repetitive motion or chronic trauma disorders were identified. One patient had a cervical spine fusion and rotator cuff surgery one and two years, respectively, before having first rib resection on the same side as the TOS.

Symptoms included pain (10 patients), paresthesia (8 patients), weakness (3 patients), swelling (4 patients), and hand symptoms (4 patients). In two patients, grip strength was decreased to the point that it interfered with day-to-day activities. Duration of symptoms varied between two days and six years.

Pre-operative evaluations were variable: of 8 electromyograms, 6 were abnormal; 3 of 3 arteriograms were normal, and 3 of 3 venograms were abnormal. Plain film disclosed one cervical rib.

Eight patients received physical therapy of at least eight months' duration. Two patients received thrombolytic therapy for venous occlusion: one underwent successful lysis of a thrombosed axillary vein two days after symptom onset; the other initially had successful thrombolysis three and one-half weeks after initial symptoms, followed by first rib resection, but the thrombosis recurred and could not be recanalized. In a third patient with documented venous compromise, thrombosis of the vein had not occurred and thrombolytic therapy was not indicated.

Surgical management consisted of 11 transaxillary first rib resections and one posterior thoracotomy. Complications consisted of five small pneumothoraces (none of which required chest tubes), one chest tube for control of a pleural effusion, and one post-operative atelectasis requiring readmission. The series involved surgery by three different surgeons; two thoracic surgeons responsible for seven cases, and one vascular surgeon responsible for three cases.

The patient who had had a cervical spine fusion and rotator cuff surgery did not experience symptom relief following either procedure, but reported relief of symptoms in the recovery room following first rib resection. Three other patients also reported immediate relief of symptoms in the recovery room.

Hospital length of stay varied from two to seven days (average, 3.6 days). In all patients except one, surgery was performed the day of admission; the exception was a patient who underwent thrombolytic therapy followed by first rib resection during the same hospitalization.

Long-term follow-up of these patients was not possible since this was a retrospective hospital chart review. However, no patient was found to have been readmitted to the hospital for problems related to recurrence of symptoms or untreated surgical pathology. No instances of arterial pathology related to thoracic outlet were identified in this review.

References

1. Kelly TR. Thoracic outlet syndrome: current concepts of treatment. *Ann Surg* 1979;190:657-652.
2. Crawford FA Jr. Thoracic outlet syndrome. *Surg Clin North Am* 1980;60:947-956.
3. Roos DB. Thoracic outlet syndromes: update 1987. *Am J Surg* 1987;154:568-573.
4. Roos DB. Diagnosis of thoracic outlet syndrome. In: Stanley BC (ed). *Current Therapy of Vascular Surgery*. New York, NY: Dekker, Marcel; 1991:216.
5. Saunders RJ, Haug C. Review of arterial thoracic outlet syndrome with report of five new instances. *Surg Gynecol Obstet* 1973;415:1991.
6. Urschel HC, Razzuk MA. Improved management of the Paget-Schrotter syndrome secondary to thoracic outlet compression. *Ann Thorac Surg* 1991;52:1217-1221.
7. Roos DB. Transaxillary approach for first rib resection to relieve thoracic outlet syndrome. *Ann Surg* 1966;163:354-358.

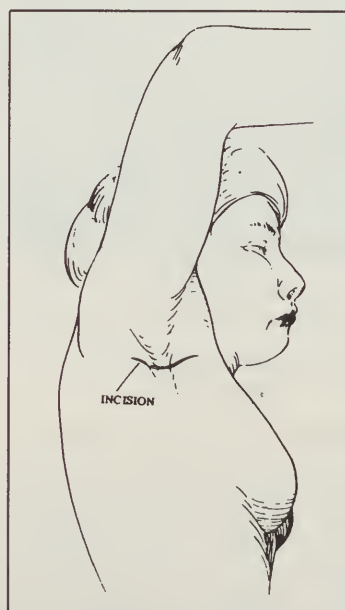


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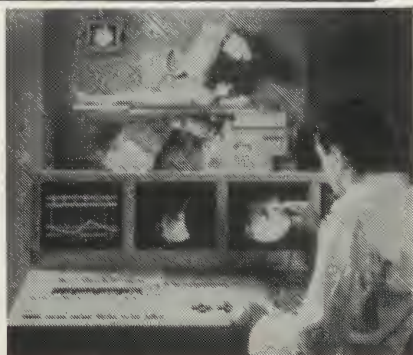
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Changes in diabetes care during the past 50 years

Dewitt E. DeLawter, M.D., Sarah E. Glover, M.D., William G. Hall, M.D.,
and Mary Louise Maras, R.D., C.D.E.

Dr. DeLawter was director of the endocrine service at Suburban Hospital from 1947 to 1985. In 1993, Drs. Glover and Hall were associate directors of the endocrine service, and Ms. Maras was associate dietitian.

No disease requires such intimate cooperation between physician and patient as diabetes mellitus. Insulin, discovered about 70 years ago, is a treatment, not a cure. Although it seems that progress in diabetes research and treatment moves too slowly, a review of accomplishments over the past five decades shows that remarkable advances have occurred.

Insulin types

Insulin had been available for 20 years when Suburban Hospital opened its doors for patient care in 1943. At that time, there were only three types: regular or clear insulin, protamine zinc or cloudy insulin, and globin insulin (introduced in the United States in 1939, used very little, and withdrawn from the market after a few years). All insulins were in two concentrations: U40/ml and U80/ml. Because the use of regular insulin required as many as four injections per day to obtain some degree of control, longer acting protamine zinc insulin (PZI) was developed during the 1930s in the hope that once daily injections would provide control. When it was found that PZI was too long-acting, physicians and patients began experimenting with mixtures of PZI and regular insulin. The mixture that became most popular was two parts regular insulin to one part PZI.

In 1946, neutral protamine Hagedorn (NPH) insulin was introduced (U.S. distribution began in 1949). NPH, which was buffered to make its duration of action similar to that of the 2:1 mixture, came to be called an intermediate-acting insulin.

The Lente insulins were introduced in 1952.¹ Lente insulin contains no foreign protein. The time of insulin action depends on whether it is in the amorphous (short-acting or Semilente) or microcrystalline (long-acting or Ultralente) form. Lente insulin, a mixture of three parts Semilente and seven parts Ultralente, is an intermediate-acting insulin. Its time of action can be modified by preparing mixtures containing more Semilente (earlier effect) or more Ultralente (later effect). When regular insulin is added to Lente, the excess zinc in the Lente binds with the regular insulin and blunts its quick

effect. It was slowly recognized, however, that regardless of the mixture prepared, a once daily injection provided inadequate control in most patients.

Scandinavian clinicians were reporting fewer complications in their patients than were being seen in the United States. The difference was that, while Scandinavian physicians were using regular insulin in multiple daily doses, U.S. physicians were striving for control using once daily or at most twice daily injections of insulin mixtures and long-acting insulin. It was concluded that diabetes could be better controlled by multiple injections in most patients and that better control probably resulted in fewer complications.

Beginning in 1950, James Moss and one of the authors (DeLawter) pooled data from their private practices and from patient records of the diabetic clinics of Suburban and Georgetown University hospitals to do clinical studies and to evaluate laboratory methods of diabetes control. The pool of approximately 3,000 patients represented a cross-section of the diabetes population in general.

Trials with insulin mixtures and multiple daily injections were conducted with many patients in our diabetes population. It was soon observed that multiple injections improved diabetes control and that patients readily accepted the multiple injections when this finding was explained to them.

When phenformin and sulfonylurea drugs became available (circa 1955) for Phase III studies and subsequent evaluation, they were used extensively by our group.²⁻¹³ When biosynthetic human insulin was released for Phase III trials, we evaluated it as well.¹⁴ Physicians and patients are still striving for insulin mixtures that are appropriate for more patients. Today, mixtures such as 70/30 NPH/regular are being marketed.

Glucose testing

Fifty years ago, patients with diabetes based the amount of insulin used daily on the amount of glucosuria present when tested by the "Benedict's solution" copper reduction method over a flame or in a water bath. Blood glucose tests were done irregularly, and unless the patient was suspected of having a reaction, almost all testing was done in the fasting state because the peak action of PZI is approximately 24 hours after the previous morning injection. When the Clinitest tablet test for glucosuria became available in the late 1940s, patients' adherence to testing recommendations improved considerably. Further ease in urine testing occurred when glucose oxidase tapes and strips and ketone test strips were marketed in the early 1950s.

Early blood glucose tests were done by the Folin-Wu method. That method was replaced by the O-toluidine method, which was easier and faster and more nearly approached a true blood glucose test result. About 1969, blood glucose test strips became available for physician use. At first, they were interpreted by comparing the test strip color with comparator blocks

on a chart. Later, the reflectance meter, a light intensity reading meter to measure the color change on the strip, took much of the guesswork out of reading and interpreting the strip result.^{15,16} The meter initially required considerable skill and a screwdriver to make adjustments to match the standardized strip supplied for maintaining control of the test method: it was certainly not patient oriented. Over the next 10 years, however, competition and experience made blood glucose testing the preferable patient method of monitoring diabetes control. Urine glucose testing is now obsolete except for patients who refuse to do tests for blood glucose.¹⁷

Injection systems

The only injection system available to patients 50 years ago was the 1 ml glass syringe with combined 40U-80U graduations and 22- to 24-gauge steel needles that constantly needed sharpening. The advent of the plastic disposable unit with an ultrafine, 29-gauge needle built into the syringe construction has made insulin administration almost painless. With the introduction of U-100 insulins, all insulin syringes now are graduated in the metric system.

Hypoglycemia

Fifty years ago, standard items in a physician's bag were a large syringe and an ampule of 50% glucose to be used for a patient having a hypoglycemic reaction. The introduction of glucagon, which allows a family member to treat a reaction, was a real boon in diabetes care.¹⁸ Patients are more at ease knowing glucagon is on hand in case they need it.

Diet

In 1943, the chief of medicine at Suburban Hospital was Edward J. Steiglitz, M.D. Dr. Steiglitz had trained with Rollin T. Woodyatt, M.D., and espoused the Woodyatt diet for diabetes, which was based on the glucose equivalent of all foods in calculating the meal plan (one gram of carbohydrate was one glucose equivalent; one gram of protein was 0.58 glucose equivalent; and one gram of fat was 0.10 glucose equivalent).

When the estimated control of diabetes was based on the grams of glucose in 24-hour urine specimens, it was easy to adjust the glucosuria by juggling the glucose equivalency of the diet, and physicians often asked patients to bring a 24-hour urine specimen at each office visit. Today, patients probably would change physicians if such requests were made with any regularity.

Because most of the staff physicians at Suburban Hospital were unfamiliar with the glucose equivalent system, they ordered Joslin-type measured and weighed diets. As almost everyone knew, however, and reluctantly accepted, few patients followed any meal plan in those days.

In 1950, the American Diabetes Association, the American Dietetic Association, and the U.S. Public Health Service jointly introduced the exchange system meal plans, which were more

acceptable and easily understood. Before the advent of the autoanalyzer method of blood glucose testing, there was a lull as long as two hours between the time blood and urine specimens were collected, test results were available, and patients could be seen. It was customary for patients to bring sandwiches, fruit, and a beverage to consume as breakfast during the waiting period. Many patients also visited the candy vending machines for supplemental nourishment. As part of the meal plan teaching program at Suburban Hospital, all patients attending the diabetic clinic could have breakfast in the cafeteria free of charge. The dietitians monitored patients as they passed through the cafeteria line, which was a very useful application of the instruction.

Education

Suburban Hospital pioneered in diabetes education using food models, foot care demonstrations, and repeated instructions about different phases of diabetes care. It was the first hospital in Maryland to be recognized by the American Diabetes Association for its education program.¹⁹

Good diabetes education must be an ongoing process that includes physicians, diabetes educators, hospital staff, and patients and their families. With the availability of quality diabetes education programs, physicians learned that hospitalization of patients with uncomplicated, newly diagnosed diabetes is undesirable and unnecessary. With this change, however, hospital administrators gradually lost interest in diabetic patient care.

The medical staff of Suburban Hospital amended its bylaws to allow podiatrists to participate in the diabetes clinic program, and the hospital administration provided the needed instruments and supplies. It was a milestone in diabetes care to have all patients seen for foot care at least every six months and to have all callous and nail care under the supervision of qualified podiatrists. Since the introduction of podiatric care in the diabetes clinic, the number of amputations has dropped considerably.

Although there is still no cure for diabetes, remarkable progress has been made in management, control, and education. Physicians and patients alike are grateful for these improvements and hope that the next 50 years will bring equally remarkable progress in diabetes care.

References

1. Hallas-Moller K, Petersen K, Schlichtkrull J. Crystalline and amorphous insulin-zinc compounds with prolonged action. *Science* 1952;116:394-398.
2. DeLawter DE, Moss JM. Tolbutamide, orally effective drug for diabetes mellitus. *Am J Nurs* 1958;58:1106-1109.
3. Moss JM, DeLawter DE, Canary JJ. The results of the treatment with tolbutamide of 200 diabetic patients: a discussion of secondary failure. *Ann Int Med* 1959;50:1407-1417.
4. DeLawter DE, Moss JM, Tyroler S, Canary JJ. Secondary failure of response to tolbutamide treatment. *JAMA* 1959;171:1786-1792.
5. Canary JJ, Stoffer R, DeLawter DE, Moss JM. The response of tolbutamide-treated patients to the stress of surgery. *Medical Annals of the District of Columbia* 1959;28:614-618.
6. Korczowski M, Kozlar L, DeLawter D. The diabetic clinic. *Hospital Progress* 1963;44:152-154.
7. DeLawter DE, Moss JM. A five-year study of tolbutamide in the treatment of diabetes mellitus. *JAMA* 1962;181:156-158.
8. DeLawter DE. Oral agents in the treatment of diabetes mellitus. *Indian Journal of Pharmacy* 1963;35:181-184.
9. Moss JM, DeLawter DE, Gallagher EJ. Oral hypoglycemic drugs. *Medical Times* 1964;2:645-655.
10. DeLawter DE, Moss JM. Aids in diabetic management. *American Academy of General Practice* 1966;33:78-86.
11. DeLawter DE. Oral drugs in the treatment of diabetes mellitus. *Md State Med J* 1966;15:28-34.
12. Moss JM, DeLawter DE. Treatment of diabetes mellitus with oral hypoglycemic drugs. *GP* 1966;34:85-88.
13. DeLawter DE, Moss JM. Twelve years' experience with oral hypoglycemic drugs. *Medical Times* 1968;96:855-864.
14. DeLawter DE, Moss JM. Human insulin: a double-blind study of its effectiveness. *South Med J* 1985;78:633-635.
15. Moss JM, DeLawter DE. Self monitoring of blood glucose. *Am Fam Physician* 1986;33:225-228.
16. DeLawter DE, Moss JM. One-minute blood glucose testing. *Am Fam Physician* 1973;8:174-175.
17. DeLawter DE, Moss JM. Evaluation of glucose oxidase strip method of blood glucose testing. *Md State Med J* 1974;23:43-46.
18. Campbell RK. New, improved glucagon emergency kit. *Diabetes Educator* 1986;13:62.
19. DeLawter DE. Diabetes education in a community hospital. *Md Med J* 1987;36:837-841. ■

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Continuing medical education at Suburban Hospital: past, present, and future

Eugene P. Libre, M.D., and Jules I. Cahan, M.D.

*Dr. Libre is the medical training officer
and Dr. Cahan is the surgical training
officer at Suburban Hospital in
Bethesda, Maryland.*

In terms of continuing medical education (CME) resources, Suburban Hospital may be the most fortunate community hospital in the country. Located in Bethesda, Maryland, across the street from the National Institutes of Health, the hospital is just minutes from the National Library of Medicine, the National Naval Medical Center, and the Uniformed Services University of the Health Sciences. George Washington, Georgetown, and Howard University medical centers are a short drive away. In addition, the hospital has regularly availed itself of faculty members from The Johns Hopkins University School of Medicine, the University of Maryland School of Medicine, and the University of Virginia School of Medicine.

From the time the hospital opened in 1943, through the late 1960s, it offered little, if any, formal CME activities. Staff physicians depended on national and regional meetings to remain current. When CME credits became mandatory for relicensure, it became apparent that Suburban Hospital would need to become involved in formal CME activities for the local physician community.

In 1969, three training officers (in medicine, surgery, and obstetrics/gynecology) were appointed to coordinate CME activities, because it was clear that the demands of a busy medical practice would make it difficult, if not impossible, for volunteers to give the time and effort required to administer such a program. In the mid-1970s, coincident with the establishment of a statewide trauma service at Suburban Hospital, the obstetrical unit was converted to an ambulatory surgery service so as not to duplicate services available in the nearby community, and the OB/GYN training officer position was discontinued. Thus, during the past 20 years, the department of medical education has consisted of two part-time training officers who are also practicing physicians in the community and a full-time administrative assistant who maintains the functioning of the office when the physicians are not present. The department has been fortunate to have the same administrative assistant for more than 16 years and the same two training officers for almost 25 years.

Because Suburban Hospital primarily provides acute care, the philosophy behind its CME programs has been to offer conferences directly related to

commonly encountered clinical problems. In addition, meetings are scheduled to allow physicians to attend with a minimal loss of time from their usual practice activities.

Formalization of continuing medical education

Grand rounds. In the 1960s, CME activities were informal and loosely structured. Small groups of physicians met to discuss tumor board cases or interesting patient problems. In the early 1970s, the need for more organized, formal instruction led to the development of a Wednesday noon meeting open to all Suburban Hospital medical staff members as well as physicians in the community (retired or at other institutions). Nursing and paramedical personnel also were encouraged to attend. This grand rounds program became known as "Selected topics in general medicine." Attendance grew steadily, from 20 to 30 people at initial meetings, to approximately 125 people per meeting by the early 1980s (the nearby availability of lunch significantly improved attendance). A smaller, more informal Friday morning teaching conference on current patient care issues and problem solving also was started.

Clinical symposia. Beginning in the 1980s, a series of clinical symposia on a variety of topics was held during the time scheduled for grand rounds. The formal didactic session was extended from one to one and one-half hours, which allowed two speakers to present 45-minute talks. Each symposium extended over four or five consecutive Wednesdays and attracted a large audience (average, 150 to 200 people per week).

Clinical conferences. In addition to grand rounds and the Friday morning teaching conference, a number of regular specialty meetings evolved. A conference in clinical oncology meets the first three Tuesdays of each month. A conference in gastroenterology meets each Wednesday. The plastic surgery conference meets the second Tuesday of the month. Psychiatry grand rounds meets each Friday. The cardiac pathology conference meets the last Wednesday of the month. On the first Thursday of the month, there is a surgical mortality and morbidity conference, and on the second Thursday each month, there is a thoracic and vascular morbidity and mortality conference. A trauma roundtable is held the fourth Thursday of the month.

Seven rules for conducting successful CME activities

Years of conducting CME activities have produced failures and successes. This experience has resulted in the following criteria:

- Hold weekly meetings in the same location.
- Begin and end meetings exactly on time.
- Schedule meetings at a variety of times that do not interfere with office hours.
- Do not schedule all-day symposia. Keep half-day symposia to a minimum.
- Encourage speakers to use a minimum of well-prepared slides.

- Encourage audience questions and interactions during the presentation and not merely at the end.
- Schedule speakers who have been previously heard and recommended.

Although these rules may result in well-attended meetings, they cannot ensure that the education provided will produce a positive change in physicians' performance and resultant improvement in the health of the population they serve. Achieving these very difficult-to-assess goals (outcomes research) requires an ongoing commitment on the part of the educators and the physicians who participate in the CME process.¹⁻⁵ Resting on past laurels does not ensure effective education. Continued effort is required to identify new areas of importance, encourage feedback from enthusiastic physicians who regularly take part in CME conferences, and keep an open mind about what works, what does not, and what can be done to make next week's conference better than last week's.

Continuing medical education in the era of health system reform

With proposed changes in health care delivery, CME programs also may require changes. Hospitals whose budgets are shrinking because of decreasing censuses and whose payments have been lowered by managed care programs may no longer have the resources to provide CME activities as they have in the past. The amount of funding for CME activities made available by pharmaceutical companies also has decreased. In addition, physicians' net income continues to decrease as their expenses continue to rise. Competition for patients has become more intense while reimbursement by third-party payors appears to continue its downward spiral. An important question to be pondered is, Will there be sufficient physician time, interest, and funds to attend CME activities?

Aware of these concerns, Suburban Hospital has made a commitment to CME for its medical staff. In January 1994, a new conference center opened as part of the overall hospital renovation and expansion. The center features a 250-seat theater/auditorium with numerous audiovisual capabilities that will allow a wide variety of in-house educational activities. Suburban Hospital looks forward to meeting the challenges that changes in medical practice will bring. It is committed to excellence in health care through education.

References

1. Haynes RB, Davis DA, McKibbon A, Tugwell PA. Critical appraisal of the efficacy of continuing medical education. *JAMA* 1984;251:61-64.
2. Gray JA. Continuing education: what techniques are effective. *Lancet* 1986;2:447-448.
3. Gardeb RM, Laidlaw JM. Effective continuing education: the CRISIS criteria. *Med Educ* 1992;26:408-422.
4. Nyquist JG. Continuing education: needs and means. *Acad Med* 1992;67(suppl):10.
5. Anon. Improving postgraduate and continuing education. *Lancet* 1987;2:464. ■

Vignette of medical history: Peregrine Wroth, M.D., (Hon.) and his Maryland descendants

Joseph M. Miller, M.D.

*Dr. Miller is a retired surgeon from
Timonium, Maryland.*

In 1608, Captain John Smith, sailing from the settlement at Jamestown into the upper reaches of the Chesapeake Bay, discovered the fertile land of Maryland's Eastern Shore, including the future Kent County. John Wroth of Durrance, England, settled in this delightful new area in 1659, the year before Charles Calvert became the third Lord Baltimore and Lord Proprietary of Maryland. Here, Wroth started a family that eventually had strong connections with and greatly influenced the surrounding community, the state, and the Medical and Chirurgical Faculty of Maryland.

Peregrine Wroth (1786-1879)

Peregrine Wroth, a member of the third generation removed from John Wroth, was born in Kent County, Maryland.¹⁻³ He attended a country school for three years and a private institution for one year. From 1795 to 1803, his education continued at Washington College, where he became well versed in Latin, Greek, and mathematics. During that time, however, the school's population dwindled from 125 to 25, no students were graduated, and Wroth left without having received a diploma.

At age 16, Wroth began to "read" medicine with his family physician, Dr. Edward Worrell. When Dr. Worrell died in 1804, Wroth was accepted as a student by Dr. Morgan Browne, but, realizing that he needed additional instruction, went to Philadelphia to attend the medical lectures given there by Drs. Rush, Shippen, Wistar, Barton, Physick, Woodhouse, and Dewees, all of whom were associated with the University of Pennsylvania. While there, Wroth joined the Philadelphia Medical Society.

After spending the next summer and autumn with Dr. Browne, Wroth returned to Philadelphia to attend the same courses. In February 1807, he left Philadelphia to continue his professional studies at home. In April, at the age of 21, he met the Board of Examiners for the Eastern Shore at Easton and successfully gained a diploma as a licentiate. On his return to Chester Town (now Chestertown), Dr. Browne invited him to become a partner. During the War of 1812, Wroth served as a surgeon in the Eighth Regimental Cavalry of Kent and Cecil counties.⁴



Peregrine Wroth, M.D. (Hon.)

Courtesy of the Medical and Chirurgical Faculty of Maryland.

In his autobiography, Wroth wrote that he prepared a petition to the Maryland state legislature at a convention in Easton in 1837, in which he suggested that a college of pharmacy be established and located in Baltimore.¹ Although Cordell⁵ reported that Wroth was one of the founders of the College of Pharmacy in Baltimore, this statement could not be confirmed: it is not mentioned in the Proceedings of the House of Delegates for 1841⁶ or in a history of the school.⁷ Regardless of his actual role in the establishment of that school, however, Wroth maintained close ties with academia. In 1841, as a thoroughly respected physician, he was awarded an honorary degree in medicine by the Medical College of Baltimore⁵ and the University of Transylvania in Lexington, Kentucky. He later became an integral part of Washington College, where he was appointed lecturer and professor of chemistry, a position he held from 1846 to 1857. Because the funds of the college were depleted, however, he received no salary. A member of the college's board of visitors for more than 30 years, he was elected president of that body in 1867.

Wroth also was active in the organized medicine of his day. At the 1830 annual meeting of the Medical and Chirurgical Faculty of Maryland, Dr. Samuel Baker proposed the formation of a library committee to select and purchase appropriate standard and periodic works in medicine for use by Med Chi members. Wroth was one of five appointed to the committee.⁸ At various times, Wroth served as an examiner for the Eastern Shore and a censor for Kent County. In 1837, he was a member of the board of visitors of the Washington Medical College in

Baltimore.⁹ He was elected Med Chi vice president three times and served as its president from 1849 to 1850.

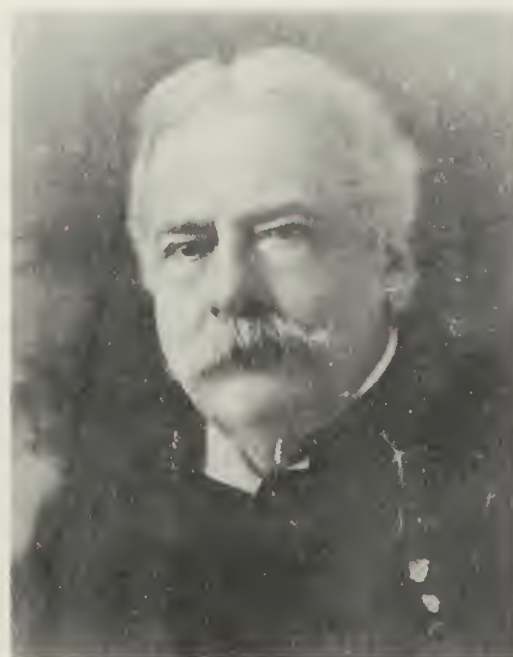
In 1845, some physicians in Boston and New York wrote to physicians throughout the United States recommending that a general convention be held in New York the following May. The proposed plan met with universal approval, the meeting was held, and plans were made for a subsequent convocation to be held in Philadelphia in May 1847. Wroth was present as a Med Chi delegate. Having received a renewed appointment from Med Chi to attend the meeting scheduled for May 1848, Wroth and 96 other physicians from Maryland became founding members of the American Medical Association.¹⁰

William Jackson Wroth (1830-1907)

The son of Peregrine Wroth, William Jackson was born in Chestertown and, like his father, was educated at Washington College. He received a bachelor of arts degree in 1849 and later, a master's degree. He graduated from the University of Maryland School of Medicine in 1852, joined Med Chi the same year, and began his practice in Baltimore. He was a vaccine physician in 1861 and 1873. Greatly interested in the Masonic Lodge, he ultimately became the Senior Grand Warden, Grand Lodge of Masons, from 1863 to 1864.

Peregrine Wroth (1845-1927)

A nephew of Peregrine Wroth, Thomas Granger Wroth (1814-1888), also was born in Kent County and received his medical degree from the University of Maryland in 1837. He married one of Peregrine Wroth's daughters, Mary Elizabeth.



Reverend Doctor Peregrine Wroth

Courtesy of the Church of the Messiah, Baltimore, Maryland.



Peregrine Wroth, Jr., M.D.

Courtesy of the Medical and Chirurgical Faculty of Maryland.

A son of this marriage was the Reverend Doctor Peregrine Wroth, also born in Kent County. He was educated at the Virginia Theological Seminary and graduated in 1872. Made a deacon in the same year, he was ordained a priest in the Episcopal church in 1873. In 1876, he became assistant minister of the Church of the Messiah in Baltimore and rector a year later.¹¹

Located at the corner of Fayette and Gay streets, Reverend Wroth's church was the only one destroyed in the great fire on Sunday, February 7, 1904 (the conflagration halted on this corner). With the help of his sons Lawrence and Peregrine, Reverend Wroth saved communion, silver pieces, lecterns, and similar items. His last act in his burning church was a recitation of the Lesser Litany.

As a result of Reverend Wroth's urging, a new edifice was erected on the old site. However, business expansion in the area, as well as a movement of parishioners to the suburbs, led to the building of another structure at Harford Road and White Avenue. When Reverend Wroth retired in 1927, he was made rector emeritus. Both he and his wife are buried in the ground upon which the church rests.

Peregrine Wroth, Jr. (1882-1956)

One of Reverend Wroth's sons, Peregrine, Jr., was a distinguished surgeon and long-time doyen of the medical profession in Hagerstown, where he moved in 1908.^{12,13} Educated in Baltimore public schools, he graduated from The Johns Hopkins University with a bachelor of arts degree and earned his medical degree at The Johns Hopkins University School of Medicine. He completed his internship and residency at the

Union Protestant Infirmary. During World War I, he served as a captain in the medical corps with the Johns Hopkins Unit at Base Hospital 18. He was a fellow of the American College of Surgeons and a founding member of the American Board of Surgery (W.O. Griffen, Jr., American Board of Surgery, personal communication). Elected Med Chi president in 1928, Dr. Wroth noted that his great-grandfather had made his presidential address to the same group nearly 80 years before.¹⁴

In the concluding paragraphs of his history of the first century of the Medical and Chirurgical Faculty of Maryland, Cordell⁸ reviews the contributions of its many members. The lack of advanced thought and sophisticated instruments restricted early members' ability to see the problems of medicine as do their modern colleagues. The accumulated knowledge of the past two centuries, however, has permitted the current members to elevate their sights and see further, but they are standing on the accomplishments of the original group. As members of Med Chi, the Wroths made many significant contributions to it.

References

1. Wroth P. Autobiography. Unpublished account courtesy of Mrs. John V. Jamison, III, a descendent of the author.
2. Hanson GA. *Old Kent. The Eastern Shore of Maryland*. Baltimore, Maryland: Baltimore Regional Publishing Company; 1967.
3. Norris J. American medical necrology. Peregrine Wroth, M.D. *Transactions of the American Medical Association* 1880;31:1101-1102.
4. McLain JH. Dr. Peregrine Wroth (1785-1879) and chemistry at Washington College, 1846-1854. *Maryland Historical Magazine* 1980;75:223-237.
5. Cordell EF. *University of Maryland, 1807-1907. Catalogue of alumni*. New York: The Lewis Publishing Company; 1907;2:43.
6. Anon. An act to incorporate the Maryland College of Pharmacy. Passed January 27, 1841. *Journal of the Proceedings of the House of Delegates of the State of Maryland*. December session, chapter 32.
7. Allen B. The founding of the Maryland College of Pharmacy. *The Maryland Pharmacist* 1991;67:25-28.
8. Cordell RF. *The Medical Annals of Maryland, 1799-1899*. Baltimore, Maryland: Williams & Wilkins; 1903.
9. Abrahams HJ. *The Extinct Medical Schools of Baltimore, Maryland*. Baltimore, Maryland: The Maryland Historical Society; 1969.
10. Stille A, Bowditch HJ. Minutes of the first annual meeting of the American Medical Association, held in the City of Baltimore, May 1848. *Transactions of the American Medical Association* 1848;1:6-46.
11. Anon. Dr. Wroth dies; 50 years rector here. *The Sun*, Baltimore, December 10, 1927.
12. Anon. Peregrine Wroth, M.D. 1882-1956. *Maryland State Medical Journal* 1957;6:217-218.
13. Anon. Dr. Wroth dead of heart ailment. *The Sun*, Baltimore, December 26, 1956.
14. Anon. Weekly talks in hospitals urged. *The Sun*, Baltimore, April 26, 1928. ■



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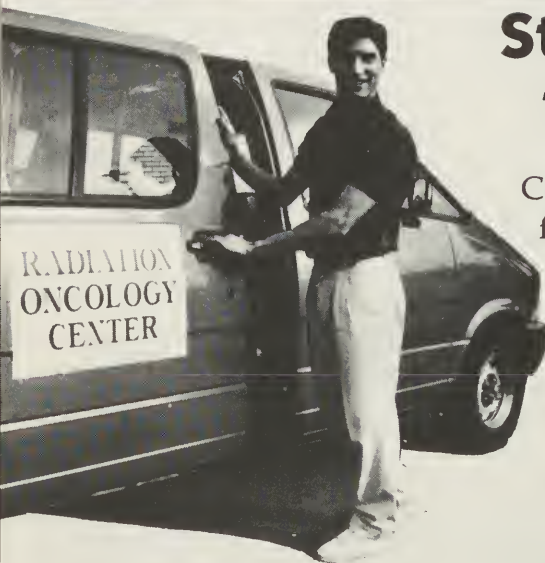
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A Clinical Moment with Endocrinology and Metabolism

Hypothyroidism in an elderly patient with congestive heart disease

Dear Doctor:
I would like to know about treatment of hypothyroidism in an elderly patient with congestive heart failure. The patient is a 74-year-old woman who complained of gradual slowing down mentally and physically in the last two years; dry, itchy skin; constipation; weight gain of 14 pounds; and marked cold intolerance. Laboratory studies showed the following values: thyroxine (T_4), 1.8 $\mu\text{g/dL}$ (normal: 5-12 $\mu\text{g/dL}$); triiodothyronine (T_3) resin uptake, 19%; and plasma thyroid stimulating hormone (TSH), 110 U/L (normal: 0.5-4.5 U/L). I am very concerned about precipitating an arrhythmia or worsening her heart failure by giving thyroid hormones. Is she hypothyroid? Should I give her T_4 , T_3 , or both? If so, how much?

Hypothyroidism is the most common disorder of thyroid function, and there are few medical treatments as gratifying to both the patient and the physician as replacement therapy for hypothyroidism. Your patient clearly demonstrates severe primary hypothyroidism and treatment with thyroid hormones is indicated. If her hypothyroidism is left untreated, she is at risk for developing the potentially lethal complication of myxedema coma. Moreover, hypothyroidism predisposes to accelerated atherogenesis.

The appropriate treatment of hypothyroidism, whether primary (thyroid failure), secondary (pituitary TSH deficiency), or tertiary (hypothalamic deficiency of thyroid releasing hormone [TRH]), involves administration of T_4 by mouth. Although T_4 actually acts by conversion to T_3 (the active intracellular hormone), administration of T_3 itself is hazardous and contraindicated because of its short duration of action associated with rapid fluctuations in blood levels that can provoke arrhythmias, particularly in an elderly patient. T_4 itself is sufficient because 80% of peripheral levels of T_3 are derived from T_4 by monodiodination. With correct treatment using T_4 alone, your patient's T_4 and T_3 should both be in the normal range.

Oral thyroxine can be replaced immediately and completely in the young, otherwise-well patient, in the amount of 1.6 $\mu\text{g/kg}$ of body weight (112.5-150.0 μg) per day. In an elderly patient with heart failure, however, treatment should begin with small quantities of thyroxine (12.5-25.0 $\mu\text{g/day}$). Increments are made monthly after clinical evaluation confirms no worsening of cardiac status, including absence of angina pectoris. Dosage can then be increased cautiously by 25 μg every four weeks until 75 $\mu\text{g/day}$ is reached; thereafter

increments of 12.5 μg can be used until full replacement is achieved.

Clinical improvement associated with normalization of T_4 and serum TSH are the most important criteria for determining that appropriate replacement has been reached. The latter is particularly helpful because very small departures in correct dosage (25 μg) are reflected in reciprocal changes in TSH concentrations. One of the best clinical indices to follow early is the patient's weight, which rapidly declines as subcutaneous mucopolysaccharides (myxedema) are mobilized and attendant sodium is excreted. Cholesterol elevations also normalize quickly, in contrast to mild anemia, which may not be resolved for months.

Complications of therapy are uncommon because synthetic T_4 is not a foreign substance that evokes allergic phenomena. However, interactions with other medications may occur. Diabetic patients may have decreased requirements for insulin or sulfonylureas and may become hypoglycemic when rendered euthyroid. In addition, cholestyramine resins can bind T_4 in the gastrointestinal tract and impair normal T_4 absorption.

It is important to emphasize that there are no hypothyroid patients with low pretreatment serum T_4 concentrations who are resistant to T_4 treatment. A patient whose serum T_4 and TSH levels reflect continuing hypothyroidism is most likely noncompliant and not taking sufficient thyroxine.

JOHN F. WILBER, M.D.

Dr. Wilber is professor of medicine and head of the endocrinology and metabolism division, department of medicine, at University of Maryland Hospital, Baltimore.

JAMES H. MERSEY, M.D.
Editor

Suggested reading: Carnell NE, Wilber JF. Primary hypothyroidism. In: Bardin CW, ed. *Current Therapy in Endocrinology and Metabolism*. Chicago, Illinois: Mosby-Year Book; 1993. ■

COMING OUT OF THE DARK

Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

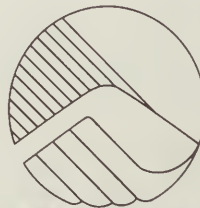
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Imaging Case of the Month.

Uncommon Injury to the Mediastinum

A 79-year-old man was brought to the emergency room with a dagger inserted at the base of the right side of the neck. According to the patient's family, he had stabbed himself after learning that he had advanced carcinoma of the prostate, ascites, and hydronephrosis.

Examination showed a thin elderly male who was alert and oriented. He appeared to be acutely and chronically ill. His pulse rate was 80 beats per minute and blood pressure was 100/70 mm Hg. There was a dagger (Figure 1) entering the base of the right side of the neck in close proximity to the right carotid artery and directed inferiorly and toward the left. There was no wheezing or stridor, subcutaneous emphysema, or bruits in the neck. There was a large amount of ascites.

Laboratory studies showed the following values: hemoglobin, 16.6 g/dL; hematocrit, 35%; and platelet count, 161,000.

Anteroposterior and lateral chest x-rays showed a blade that had entered the base of the neck on the right and crossed posteriorly and inferiorly with the tip projected in the left hemithorax (Figure 2). The left hemidiaphragm was elevated, as it was on films dating back to 1982.

Bronchoscopy showed no blood in the trachea or laceration of the tracheal wall. Esophagoscopy showed no indication of injury to the cervical or thoracic esophagus. Through an oblique incision in the right side of the neck, the blade was

exposed after control of the right carotid artery and jugular vein. The dagger had traveled anterior to the spine and posterior to the carotid sheath. The blade was withdrawn slowly. There were no changes in the patient's vital signs and no indication of arterial or venous bleeding. The dagger was 25 cm in length; 16.5 cm had penetrated the neck and mediastinum. Chest x-rays showed no pneumothorax or effusions and no blood was transfused during the patient's hospitalization.

Following a normal esophagogram, a drain was removed from the right side of the neck on the fourth postoperative day. On the seventh postoperative day, the patient was discharged from the hospital tolerating a soft diet.

Penetrating injuries to the neck and mediastinum may pose diagnostic and therapeutic challenges inasmuch as they may produce severe compromise to major arteries, trachea, esophagus, and heart. The surgeon must be prepared to explore the neck and mediastinum, through a midsternotomy if necessary, or perform thoracotomies if required. Sometimes, as in this case, the structures of the neck and mediastinum are spared injury.

L. ALBERTO NUNEZ, M.D.

Dr. Nunez is attending thoracic surgeon at Suburban Hospital and clinical assistant professor of surgery at Georgetown University School of Medicine in Washington, DC. ■

Reprints: L. Alberto Nunez, M.D., 8218 Wisconsin Ave., Suite 407, Bethesda, MD 20814



Figure 1.



Figure 2.

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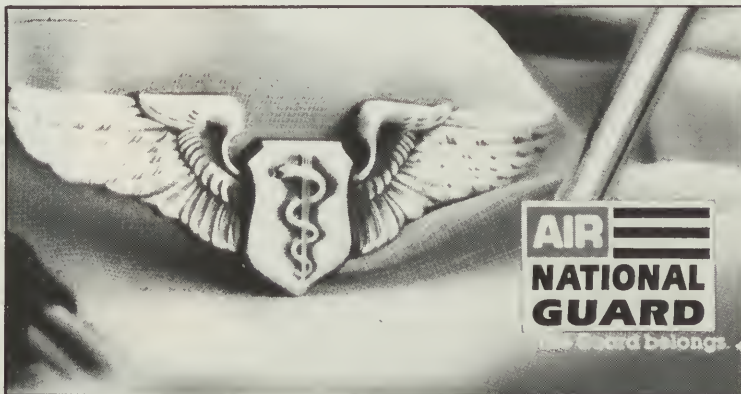


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WORD ROUNDS

Bart Gershen, M.D.

The numbers game

A logic puzzle asks, If the maximum number of hairs on a human head does not exceed 6,000,000, would it then be true that in the city of New York there are many people with exactly the same number of hairs on their head?

Numbers, digits, figures, tallies, amounts.

Our world is flooded by figures, discouraged with digits, nameless by numbers—but dysfunctional without them. From the sieve of Eratosthenes to quantum mechanics, we depend on numbers to comprehend our universe—and to buy groceries.

Some 4,000 years ago, in the land between the Tigris and Euphrates rivers, the Babylonian culture arose. The area was known as **Mesopotamia** since it was *mesos* (Greek 'between') *potomos* (Greek 'river'); that is, in the valley between two rivers. *Potomos* may be found hidden in the word **hippopotamus**, 'river horse'. Greek *hippos* 'horse' is in **hippodrome**, a place to run horses. The contraction *philo* (Greek 'to love') + *hippos* yields the name **Philip**—someone who loves horses.

One of the remarkable inventions of that Babylonian society was the **abacus**, a device that could perform sophisticated calculations. An abacus had parallel strings onto which were threaded colored pebbles that could be moved rapidly along a row, each string representing numbers in the tens, hundreds, or thousands. **Calculation** and the **calculus** evolved directly from the abacus, a reference to the small stones (Latin *calculus* 'stone

or pebble', which in turn derives from *calx* 'limestone', as in **calcium**).

Digits are numbers, too, of course, derived from the ancient—and still popular—practice of counting on one's fingers (Latin *digitus* 'finger' or 'toe'). A number consisting of two figures (e.g., 01) is a **binary** number. One of its two digits is known as a **binary digit**, the acronym for which is **bit** in computer terminology. Eight bits constitute a **byte**, which is the basis for rating the memory capacity of a computer's hard disk (e.g., 200 megabytes— 200,000,000 bytes) or the size of a computer program (e.g., 700 kilobytes— 700,000 bytes).

Monos is the Greek word for 'one'. Its combining derivative is *mono*, as in **monocular**. **Monogamy** (Greek *gamos* 'marriage'), **monograph** (Greek *graphein* 'to write'), **monogram** (Greek *gramma* 'letter', as in **grammar** and **grammatical**), and **monologue** (Greek *legein* 'to speak') are also representative examples. A **monolith** is a figure made from a single stone, such as those at Stonehenge or Easter Island (Greek *lithos* 'stone', as in the **Paleolithic** era, or in **nephrolithiasis** and **lithotripsy**.) A **monolithic** philosophy is unyielding and one-dimensional. **Mononucleosis** inundates the blood stream with white blood cells containing single nuclei (**monocytes**). A **monobactam**, such as **aztreonam**, is a **monocyclic beta-lactam**.

The Latin for 'one' is *unus*, as in **unilateral**, **universe**, and **uniform**. In this world there appear to be

more *mono* 's than *uni* 's, but the choice keeps us from being too **unidimensional** or **monotonous**.

The prescriptive **q.d.** stands for *quaque die* 'every day', avoiding the need for either Greek or Latin numerals.

Duo is the Latin for 'two', as in **duet**, **dual**, and **duplicate**. The **duodenum** was thought by early prosecutors to be twelve fingerbreadths long (Latin *duodeni* 'twelve', which in turn derives from *duo* + *decem* 'ten', that is, two plus ten). The prescriptive **b.i.d.** comes from the Latin *bis* ('twice') *in die*. The **biceps** has two heads (Latin *bis* + *caput* 'head'), and a **bicuspid** valve or tooth possesses two points (Latin *cuspid*). Severe aortic regurgitation causes the carotid pulse to become **bisferiens** (Latin *bis* + *ferio* 'to strike', that is, M-shaped or striking the finger twice during each systole). A **biscuit** is something that is baked twice (Latin *bis* + *coctus* 'cooked' or 'baked'). The Germans had a similar name for it: *zwieback*.

Tres is the Latin for 'three' and yields the combining form *tri*. The **triceps** has three heads, the **tricuspid** valve has three cusps, and a **tripod** has three feet (Greek *pous* 'foot'). A **triangle** has three angles. **Trigonitis** is inflammation of the lower, triangular segment of the urinary bladder (*tri* + *gonia* 'angle'). **Trigonometry** stems from *trigono* + *metron* 'measure', the measurement of three-angled structures. A **goniometer** is an orthopedic instrument that measures the angle—or range—of motion of a joint. **Nitroglycerine** is glyceryl trinitrate, which expands arteries or explodes buildings, depending on your specialty.

In ancient Rome, people often gathered on street corners to gossip and

lament their circumstances—not unlike those of us today. Three roads frequently converged at common intersections, which meant that early truants were able to loiter on three street corners at the same time (Latin *trivium* 'place where three roads connect', which derives from *tri* + *via* 'road'). Thus, the spot at which those critical discussions were held created a word that best describes them: **trivial**.

The Latin 'four' is *quattuor*, in Greek it is *tettares*. The respective combining forms of each are *quadri* and *tetra*. A **quadrangle** is a plane geometric figure with four angles and four sides. A **quart** (Latin *quartus* 'fourth') is one-fourth of a gallon, and a **quartet** boasts four singers. A **quarterhorse** is any breed of horse that reacts quickly to its rider's commands. These equines are used by both cowboys and city slickers to herd cattle, their name arising from the horse's ability to accelerate quickly for up to a **quarter** of a mile.

Something that is said to be **catty-cornered** has four corners, from the French *quatre* 'four', i.e., quatre-cornered.

Carillons were originally composed of only four bells and known by their Latin designation *quaternion*, later evolving to the French *carrignon*.

Quartan malaria (*Plasmodium malariae*) causes four-day intervals of fever, the **quadriceps** is a four-headed muscle, and a **quadriplegic** has paralysis of all four extremities (Greek *plege* 'stroke', as in **cycloplegia**, loss of accommodation due to paralysis of the ciliary muscle). *Cyclo* derives from the Greek *kyklos* 'circle' and often refers to the eye or ciliary muscle, as in **iridocyclitis**. **Ku Klux** is a derivative of *kyklos*, referring to the *circle* of the Klan.

In 1333, the Black Death, caused by the tiny organism *Yersinia pestis*, began in Cathay (China). During that year, Genoese merchants returning home with silk and furs were ambushed by a band of Tartar pirates at Caffa, a Crimean trading post. The fierce battle ended abruptly, as the Mongol forces were **decimated** by the plague (Latin *decem* 'ten'. See below.) Before retreating, however, the Tartars catapulted their dead over the defensive wall into the village. Many of the merchants became infected. Some died on the trail, but the survivors carried the plague back to Italy and the rest of Europe. Before it finished, the Black Death had destroyed one-quarter to one-half of Europe's population.

Italian physicians soon realized that an individual who appeared healthy might, in fact, be incubating the disease. The authorities, therefore, sequestered all arrivals to the city of Genoa and allowed no contact with the general populace for a period of 40 days, the **quarantine**, from Italian *quarantina* '40 days'.

The Greek for 'five' is *pente*, the combining form for which is *penta*. In Latin, *quinque* is 'five' and *quintus* means 'fifth'. In May 1934, a 24-year-old woman in Callender, Ontario, delivered five babies: Emilie, Yvonne, Cecile, Marie, and Annette, each averaging 2 pounds 11 ounces. The Dionnes became the world's first surviving **quintuplets**.

Ancient philosophers and alchemists believed the universe was composed of four constituents: earth, air, fire, and water. They theorized, however, that there must be a fifth element, a supreme material from which the heavens were formed. They spoke of this fundamental substance as the *quinta essentia*—

the fifth essence. It was, alas, never discovered, but has given birth to **quintessence**, the consummate manifestation or quality of a thing.

The **Pentagon** has five angles, as well as five sides. A **pentathlon** is an athletic competition with five events (*penta* + *athlon* 'prize' or 'contest'). The **Pentateuch** comprises the first five books of the Old Testament Bible (Greek *penta* + *teuchos* 'an implement or book'). **Pentobarbital** (Nembutal) is named for a five-carbon methylbutyl group that is attached to the parent barbituric acid nucleus. The intravenous anesthetic **pentothal** is also named for its methylbutyl appendage, the 'thal' resulting from **thiobarbiturate** + the suffix *al*. **Pentecost** is the fiftieth day after Passover, a Jewish holiday known as *Shavuot*. In the Christian religion, Pentecost is the seventh Sunday (50 days) after Easter, commemorating the descent of the Holy Spirit upon the apostles.

The Latin for 'six' is *sex* as in **sextet**. A college **semester** comes from Latin *semestris* 'a six-month or half-yearly period', which in turn results from *sex* + *mensis* 'six months'. (A **menstrual** cycle occurs monthly, which ultimately derives from the Greek word for 'moon': *mene*.)

The *sexta hora* in ancient Rome was the sixth hour after sunrise. Since dawn was assumed to be 6:00 a.m., the sixth hour was 12:00 p.m. In southern climates, the sun is almost directly overhead at noon, making energetic work difficult. That is how the **siesta**—the Spanish derivative of *sexta*—originated.

The word **noon** also has an interesting history. Originally the term was *nona hora*, the ninth hour after sunrise or 3:00 p.m. In the King James Bible

published in 1611, Mark's account of the crucifixion states "there was darkness over the land until the ninth hour" (15:33). In the Roman Catholic Church, a daily service called *nones* was held at that hour. By the twelfth century, however, the service had been moved to an earlier hour. Eventually it was held at 12:00 p.m.; thus, the **noon** hour.

The original Roman calendar had ten months and began with March. A Roman year looked like this:

- **March:** *Martius* 'of Mars'
- **April:** *Aprilis* 'second month'
- **May:** *Maia*, an earth goddess
- **June:** for the goddess *Juno*, wife of Jupiter
- **July:** *quintilis* 'fifth month', later named for **Julius Caesar**
- **August:** *sextilis* 'sixth month', later named for **Augustus Caesar**
- **September:** *septem* 'seven'
- **October:** *octo* 'eight'
- **November:** *novem* 'nine'
- **December:** *decem* 'ten'

Decem is the basis for our **decimal** system, a **decibel**, a **decathlon**, and a **decade**. Boccaccio's *Decameron*, written in 1353, was a collection of tales narrated by a group of Italians during ten days of a plague epidemic. In ancient Rome, the victorious army arbitrarily executed every tenth prisoner, a policy known as **decimation**. Today it signifies almost total annihilation.

The Roman year was only 304 days long, making it quite difficult for farmers who depend on a solar year to predict their planting season. In an unsuccessful attempt to rectify the problem, two additional months were added, *Januarius* and *Februarius*, named respectively for the two-faced god Janus, and *Februa*, the Roman festival of purification. Ultimately, **January** was

assigned to start each new year, since elected officials took office on the first of that month (even then the world seemed to revolve around politicians). Finally, in 46 B.C., Julius Caesar ordered the astronomer Sosigenes to modify the calendar to make it synchronous with the seasons. The assignment appeared to have been accomplished by incorporating 445 days into that year—a period known by the Romans as the *year of confusion*.

Unfortunately, after all that work, the **Julian** calendar was still not coincident with the seasons. So, in 1582, Pope Gregory XIII formulated a new strategy that corrected the differences. We continue to use it today—the **Gregorian** calendar.

You now understand why the names of our ninth, tenth, eleventh, and twelfth months are respectively derived from the numbers seven, eight, nine, and ten.

There is still the puzzle, however, concerning a relationship between hair and the population of New York City.

I'll bet all my readers know the answer to that one. ■

STRAIGHT Forward

INFORMATION

FOR AUTHORS

Straight Forward, a quarterly publication by the Physician Rehabilitation Committee of the Medical and Chirurgical Faculty of Maryland, informs Maryland physicians and other health care providers of developments in the areas of substance abuse, mental health, impairment, and recovery.

To accomplish this goal, the editorial consultants seek original informative or philosophical manuscripts on addiction, recovery, practice/patient management, and mental health. Calls for manuscripts on specific subjects will appear in future *Straight Forward* issues.

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Book Reviews

Falling Through the Safety Net. Insurance Status and Access to Health Care. Joel S. Weissman, Ph.D., and Arnold M. Epstein, M.D., M.A. Baltimore, Maryland: The Johns Hopkins University Press. 1994. 192 pages. \$40.00 (hard cover); \$14.95 (paperback).

We are in the midst of a passionate national debate on health care and its reform. Accessibility to the health care system, universal coverage, cost, and affordability are the big issues. The impact of any reform on personal medical freedom and choice and on the quality of care have generated fears and concern.

This book is a very recent and timely publication on the issues of accessibility to health care and universal coverage. The two authors are from the department of health care policy at Harvard medical school and the department of medicine at Brigham and Women's Hospital in Boston. Hillary Rodham Clinton wrote the foreword.

In eight chapters and with many figures and tables, Weissman and Epstein present a book clearly and methodically written, based on research and extensive review of the literature. They provide a conceptual framework for the study of health insurance and access and an analytic model for assessing access to health care. They describe the various types of insurance and the impact of insurance coverage on a person's health and utilization of health services. They also address the influence of nonfinancial barriers to access. They describe the dynamics of insurance coverage and insurance status in this country, emphasizing that "each of the three circumstances—permanent uninsurance, transient uninsurance, and underinsurance—has different implications for policy making. Understanding the size and characteristics of these populations is an important first step toward health system reform." The source, location, and convenience of health services, the quantity and quality of utilization, and outcome indicators of satisfaction, health status, and mortality should be considered.

The authors describe the history and structure of health insurance in the United States and a brief history of the proposals and efforts for national health insurance in this century. The proposals for reform fall into four broad categories: all government, universal coverage; compulsory, private universal coverage; incremental public strategies; and incremental private strategies. Weissman and Epstein offer criteria that policy makers, health professionals, and the general public can use to determine the likely impact of health system reform on access to care. They conclude: "Among industrialized western nations, the United States is unique in that it does not have universal coverage through a national system of health care. What services patients get and how well they do depend in part on how they pay for their care. . . . We need to understand better the social and economic costs of muddling forth as we do now and contrast them with the costs associated with different options for reform. Doing nothing is not a viable alternative."

The book is well referenced and indexed. It has a summary of the national surveys and major studies on access to health care and a list of abbreviations and statistical terms. It is a stimulating and scholarly book that provides some of the badly needed background for action during the present national health debate. Health professionals and providers, as well as health researchers and policy makers will find this book very valuable.

CHRIS PAPADOPOULOS, M.D.,
F.A.C.C.
Baltimore, Maryland ■

Death Notification, A Practical Guide to the Process. R. Moroni Leash, L.C.S.W., M.S.H.C.A. Hinesburg, Vermont: Upper Access Books. 1994. 277 pages. \$19.95.

Death Notification, A Practical Guide to the Process is an interesting and useful book. Mr. Leash is a clinical instructor in a large teaching hospital in California. He has written a sensitive guide for a difficult subject. Based on his experiences in a regional trauma center, this comprehensive manual offers practical suggestions for professionals dealing with death. Without choosing a particular psychological theory, Mr. Leash describes various aspects of the experience. He divides the process into four stages, then adds chapters on organ donation, grief reactions, and crisis intervention.

What makes the book so readable is the straightforward style, minimal use of jargon, and numerous vignettes. For ex-

ample, Mr. Leash presents some do's and don't's about setting the stage for notifying families. In describing assessment and management of bereavement, his topics range from supportive listening to mental status examinations to viewing the body. Throughout the book, he addresses the concrete tasks of grieving, as well as the psychological ones.

All the stories seem quite believable and include glaring examples of how not to talk to any person who is acutely upset. (Naturally, many of the negative examples are "committed" by physicians, while the rescue is usually accomplished by a skillful, caring, dedicated social worker.) These moral tales are told in the first person by the author. Fortunately, he himself makes the right comment at the right time. Aside from the doctor-bashing, his stories are entertaining.

This anecdotal approach is both enlightening and in a way disturbing. The final chapter examines research, which is quite limited in this important segment of

patient care. While words themselves do matter and do have impact, it is ongoing concern that allows wounds to heal. There is as yet little "science" to guide the practitioner.

The appendixes are comprehensive and fascinating. They include such topics as media notification, tissue donation, legal next-of-kin determination, and family funeral checklist.

Death Notification is desirable, but not required, reading for physicians. It is a valuable resource and it is definitely thought provoking. A seminar course on the topic should be included both in medical school and residency. Continuing medical education courses also should address the topic. Videotapes would be a valuable adjunct.

JOHN W. BUCKLEY, M.D.
Towson, Maryland

BONNIE BARANOWSKI, L.C.S.W.
Towson, Maryland ■

TO OUR READERS

The Editorial Board of the *Maryland Medical Journal* invites you to submit reviews of books, videos, and films of interest to the medical profession. Bringing your evaluation and analysis to the attention of your colleagues will be informative and stimulating. Send your report to: Chris Papadopoulos, M.D., Book Review Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, Maryland 21201.

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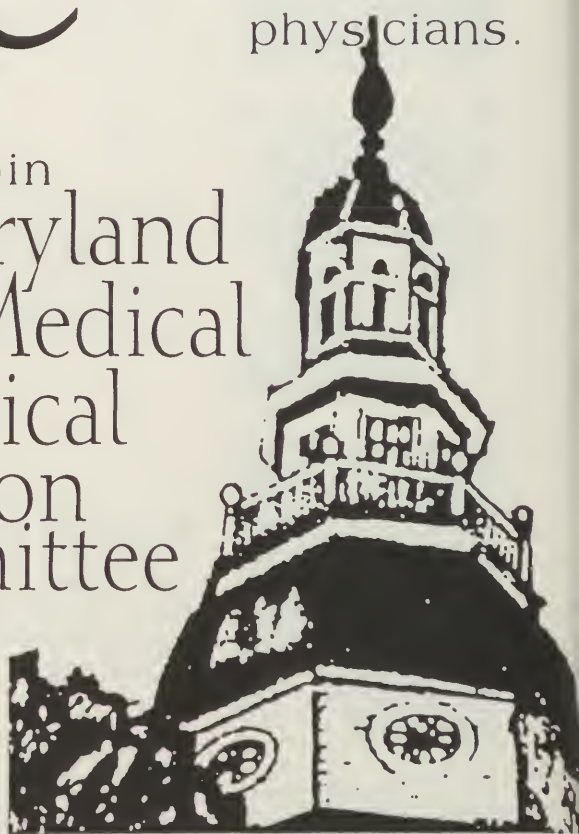


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HAEMOPHILUS INFLUENZAE B (HIB) DISEASE FACT SHEET

Haemophilus influenzae type b (Hib) is a bacterium that causes serious infections

Disease usually occurs in children 2 months to 5 years of age.

Hib causes meningitis and other serious infections

Hib can enter through the nose or throat and then can spread to cause meningitis (an infection of the coverings of the brain and spinal cord). Pneumonia, ear, skin, joint, and blood infections also occur.

Hib is spread by droplets or by direct contact

Hib is carried in the nose and throat of children and adults who may be healthy or have mild symptoms. It is then spread to the next person through contact with discharges or droplets from the nose or mouth.

Symptoms to look for:

- Meningitis
 - Fever
 - Sudden vomiting
 - Drowsiness
 - Stiff neck
 - Extreme irritability
- Other infections
 - Fever
 - Symptoms at site of infection (for example: skin or joint that is red, tender, or swollen)

See a doctor immediately for treatment

Treatment with antibiotics should be started immediately to stop the infection from causing brain damage or death.

Prevent infection with Hib vaccine

Hib conjugate vaccine is recommended for all children starting at 2 months of age. Hib vaccine is recommended for all children under 5 years of age who have not been previously immunized, and required if they attend child care centers. Others may need Hib vaccine if they have risk factors for Hib disease.

People in close contact with a case may need an antibiotic

All those who live in the same house with a child who has Hib disease (except for pregnant women) may need a drug called rifampin to prevent getting or spreading Hib. Children and employees in child care settings who have been exposed to a case may also need rifampin. Check with your doctor or your local health department for advice.

HAND, FOOT, AND MOUTH DISEASE (COXSACKIEVIRUS) FACT SHEET**Hand, foot, and mouth disease is caused by a virus**

Coxsackievirus disease, also known as hand, foot, and mouth disease, usually affects the inside of the mouth and the palms of the hands, fingers, and soles of the feet. It is commonly caused by coxsackievirus A16 (an enterovirus), and less often by other types of coxsackieviruses.

Anyone can get hand, foot, and mouth disease

Young children are primarily affected, but it may be seen in adults. Most cases occur in the summer and early fall. Outbreaks may occur among groups of children especially in day care centers or nursery schools. The incubation period is usually 3-5 days.

Hand, foot, and mouth disease is usually spread through person-to-person contact

The virus is spread primarily from the feces of infected persons to the mouth of the next person. It is spread also by the respiratory tract from mouth or respiratory secretions, by person-to-person contact, and from saliva on hands or toys. Direct contact with the skin blisters may also spread the virus.

The symptoms are much like a common cold with a rash

The rash appears as ulcers in the mouth, on the inner cheeks, gums, sides of the tongue, and as bumps or blisters on the hand, feet, and sometimes other parts of the skin. The skin rash may last for 7-10 days.

Hand, foot, and mouth disease can be shed for several weeks

People can spread the disease when they are shedding the virus. The primary means of transmission is from the feces. The virus can be shed for several weeks after the onset of infection. The virus is also shed from the mouth and throat when a person has cold-like symptoms. The virus has also been found in the fluid from the skin blisters. Greatest communicability is during the acute phase/stage of illness when people are feeling ill.

There is no specific treatment for the virus that causes hand, foot, and mouth disease**Help prevent and control the spread of hand, foot, and mouth disease by:**

- Washing hands well, especially after going to the bathroom, changing diapers and handling diapers or other stool-soiled material
- Covering the mouth and nose when coughing or sneezing
- Washing toys and other surfaces that have saliva on them
- Children should be excluded from child care or school settings if there is a fever and/or ulcers in the mouth, that is, when the child may be feeling ill
- If blisters/lesions are open and weeping, children should be excluded from child care settings until the blisters are dried and crusted

HEAD LICE FACT SHEET

Head lice are small insects

They live on the hair and scalp of humans where they feed on blood.

Anyone can get head lice

You can catch head lice by coming in direct contact with an infested person's head or with personal belongings such as combs, brushes, and hats. Head lice can spread as long as lice or eggs remain alive on the infested person or clothing. Pets (dogs and cats) do not catch head lice.

Itching of the head and neck is common with head lice

Itching may be mild to intense. Other signs to look for can sometimes include swelling of neck glands, fever, or muscle aches.

Head lice are diagnosed by the presence of adult lice or eggs (nits)

Lice may be difficult to see, but nits may be seen as specks "glued" to the hair shaft. Nits range in color from yellow to grey.

Head lice can be treated

Medicated shampoos or creme rinses kill lice. Permethrin-based drugs (such as Nix) are the treatment of choice and may be purchased over-the-counter. Follow package directions closely. Fine-toothed combs are available to help remove nits from hair. Wash hats, scarves, clothing, towels and bed linen in hot water and dry in a hot dryer. Tie up non-washable items in a plastic bag for 10 days. Wash combs and brushes with a disinfectant and hot water.

Spraying classrooms or homes with insecticides is not recommended

Floors, rugs, pillows, and upholstered furniture should be vacuumed. The lice die when they are away from the warmth of a human body for more than 48 hours.

Infestations can be prevented

- Avoid physical contact with a person who has lice
- Do not share combs, brushes, hats, scarves, ribbons, or other personal items
- Household members and close contacts of a person with head lice should be examined and treated if they are infested
- Exclude children with head lice from school or day care until the morning after treatment

HEPATITIS A FACT SHEET

Hepatitis A is caused by a virus

The hepatitis A virus causes an infection of the liver. The virus is passed in a person's feces (stool).

Anyone can get hepatitis A if they haven't had it before

People can get it from another child or adult who has hepatitis A, or by eating food contaminated by someone who has the hepatitis A virus. The symptoms start about 4 weeks after infection (with a range of 2-6 weeks).

Symptoms to look for:

- Yellow skin and eyes (jaundice)
- Brown, tea-colored urine
- Diarrhea
- Fever
- Loss of appetite
- Stomach pains

Not everyone gets sick from hepatitis A

About half of the adults who catch hepatitis A get sick. Only a few children get sick when they catch hepatitis A. But all people who catch the virus can spread it to others. The virus is in the stool for about 3 weeks: 2 weeks before illness starts and one week after.

Handwashing can stop the spread

Wash hands with soap and water:

- After using the toilet
- After changing diapers
- Before touching food and before eating

A shot may help

A shot called "IG" (immune globulin) can help stop hepatitis A if given early enough to people who had close contact with a case.

See your doctor or call the health department

If you or people in your family have these symptoms or if you have been in close contact with someone who has hepatitis A, call your doctor or your local health department.

FIFTH DISEASE (ERYTHEMA INFECTIONOSUM) FACT SHEET**Fifth disease is a mild rash illness**

It is caused by a human virus called parvovirus B19 and primarily affects school age children.

Many people already have had fifth disease

Most people get infected between 5 and 14 years of age. It is estimated that about half the adults in the United States have already been infected with parvovirus B19 and therefore can't catch it again.

A red, patchy rash on the face, "slapped cheeks," is most common

The rash may appear on other parts of the body (such as the arms, trunk, buttocks, and thighs). Other symptoms such as fever, headache, bodyache, sore throat, congestion, runny nose, cough, nausea, or diarrhea may come before the rash. In adults, joint pains or arthritis is likely to occur. Symptoms usually start 4 to 20 days after a person has been exposed. About 25% of all cases have no symptoms. In both children and adults, the disease is usually mild and recovery occurs without problems.

A person with fifth disease usually spreads the virus before the rash starts

The virus is spread by exposure to airborne droplets from the nose and throat of infected people. The virus can also be transmitted by blood or blood products.

There is a blood test, but it is not widely available

A blood test for antibodies is used to see if a person is currently infected or was infected in the past. The blood test is used primarily for pregnant women exposed to fifth disease. In most cases, the disease is diagnosed based on the appearance of a typical rash.

There is no specific treatment or vaccine for fifth disease at this time**Some people are at higher risk if they get fifth disease:**

- Fifth disease in a pregnant woman who has not had fifth disease before can cause problems for the unborn baby. Miscarriages and stillbirths are uncommonly associated with parvovirus infection, but are more frequent when infection occurs during the first half of pregnancy. Parvovirus infection later during pregnancy can lead to anemia in the fetus, prematurity or stillbirth.
- People with immunodeficiency or chronic red blood cell disorders (such as sickle cell anemia) may get severe anemia if they catch fifth disease.

Exclusion of children with fifth disease from school or day care is not recommended

The greatest risk of viral spread is before symptoms begin. So few control measures are necessary.

Those at risk should check with their doctor

Pregnant women, women considering pregnancy, and others at risk should realize that they may catch fifth disease from family members, others in the community, and in child care, school or other occupational settings. Pregnant women and others at risk should consult with their physicians if they have been in contact with a case of fifth disease. The doctor may want to check the blood to see if they are susceptible. Routine exclusion of those at risk from settings where fifth disease is occurring is not recommended since the risk depends on whether the person is already immune. Each exposure needs to be individually evaluated.

GIARDIASIS FACT SHEET

Giardiasis is an intestinal disease caused by a parasite

The parasite, called *Giardia lamblia*, causes people to have diarrhea.

Anyone can get giardiasis. At increased risk are:

- Children who attend child care centers
- People in close contact with children or adults who have giardiasis
- People who travel to some foreign countries where the water supply and food may carry *Giardia*
- People who drink surface water that has not been properly treated
- Men who have sex with other men

Giardia are shed in feces

Giardia are passed in the feces of humans, wild animals, and pets. *Giardia* can be shed in the feces for weeks to months, even if the person has no symptoms.

The parasite is spread from person to person by close contact with someone who has the organism (for example, contact with diapered children). Outbreaks can occur in child care centers. Feces also can contaminate lakes, reservoirs, and streams, and giardiasis can result when people drink the untreated water.

Symptoms to look for:

Many people can catch giardiasis or carry the organisms without having any symptoms.

It takes 5 days to 4 weeks from exposure to the onset of symptoms

Treatment with specific medications can shorten illness.

Prevent infections:

- Wash hands after using the bathroom, after handling diapers, and before fixing food or drink.
- Avoid drinking improperly treated water, for example, when camping or during foreign travel. Municipal water supplies with filtration are usually safe.
- Keep children with diarrhea out of swimming pools. Have diapered children wear tight diaper covers in swimming or wading pools.
- Maintain swimming pools through adequate disinfection and filtration. If a child or adult has a bowel movement in a swimming pool, have everyone get out of the water and increase the chlorine to 3 to 5 parts per million (ppm) for 30 minutes. Water in unfiltered wading pools should be emptied and refilled.

GONORRHEA FACT SHEET

Gonorrhea is a sexually transmitted disease (STD) caused by a bacterium

Neisseria gonorrhoeae (gonococcus) is the bacterium that causes gonorrhea.

Gonorrhea is spread by sexual contact, and from mother to baby during delivery

The bacterium is found in infected body fluids from the penis, vagina, mouth or rectum, and spread by direct sexual contact (touching, rubbing). Babies eyes can get infected if their mother has a cervical infection at the time of birth.

Symptoms to look for:

- Discharge from the penis, vagina, or rectum
- Sore throat, possibly with difficulty swallowing
- Bad cramping or severe pain in the pelvic area in women (pelvic inflammatory disease, or PID)
- Pain in the testicles in men
- Pain when urinating

The gonococcus may get into the blood and may rarely settle in other parts of the body causing infection of the joints, skin, heart, brain, etc. Symptoms can start from 2 to 7 days after infection. Many people can have gonorrhea and spread it without having any symptoms at all.

Gonorrhea can be treated with antibiotics

In the past, penicillin was used to treat gonorrhea. Now other antibiotics, such as ceftriaxone, are used since the gonococcus is often resistant to penicillin. Anyone treated for gonorrhea should also be treated for chlamydia infection, another STD.

Gonorrhea is preventable

- Avoid infection by being monogamous, that is, only have sex with one person who only has sex with you
- Avoid unprotected sex—use condoms
- Know the signs of gonorrhea

If you think you or your partner(s) have gonorrhea or another STD, see your doctor and don't have sex

If you have gonorrhea, tell your partner(s) so they can be treated

Don't have sex until both you and your partner(s) have completed treatment.

MEDICAL POLICY

SUBJECT: SPECT SCANS

EFFECTIVE DATE: May 15, 1994*

| | | |
|--------------------|---------------------|---------------------|
| CPT/HCPCS Code(s): | Cardiovascular: | 78464, 78465, 78469 |
| | Brain: | 78607 |
| | Bone: | 78320 |
| | Tumor localization: | 78803 |
| | Liver: | 78205 |
| | Kidney: | 78710 |

Description of Service: Single photon emission computed tomography (SPECT) is a diagnostic imaging modality that involves the use of radiopharmaceuticals to produce internal body images by section tomography.

1. CARDIOVASCULAR IMAGING - Studies which produce images of the heart in motion. Covered by Medicare effective 4/25/91.

Clinical Indications: Refer to this carrier's medical policy guidelines entitled *Myocardial Perfusion Imaging*.

2. BRAIN IMAGING* - Coverage is provided effective for services rendered on and after 5/15/94 for SPECT BRAIN IMAGING for the following indications:

- a. Dementia:
 - To aid in the differential diagnosis of dementia.
 - To assist in the diagnosis of Alzheimer's disease in patients with unclassified dementia.
- b. Cerebrovascular disease:
 - To assist in the diagnosis of *acute* stroke in patients with uncertain diagnosis.
- c. Epilepsy:
 - To assist in the localization of epileptic foci in patients who are not responding satisfactorily to standard therapy.

ICD.9.CM Code(s):

- Dementia: 780.9 Amnesia, memory loss
- Acute stroke: 290.40, 435.9, 436
- Epilepsy: 345.11, 345.21, 345.31, 345.41, 345.51, 345.61

Utilization Guidelines:

Benefits for follow-up examinations for dementia are limited to those situations where there is an abrupt change in a patient's clinical condition which requires altered medical treatment.

3. BONE IMAGING - Coverage has been provided effective 7/1/90 for the following:

To provide improved definition of bone physiology in those situations where a previous bone scan did not explain the clinical symptoms, i.e., bone pain;

To aid in diagnosis of spondylolysis;

To evaluate for facet arthropathy.

ICD.9.CM Code(s):

- Abnormal radiological findings: 793.0, 793.7 or abnormal results of function studies (scans): 794.00 and
- Diagnosis code for breast cancer: 174.0 - 174.9, 198.81, 238.3 or prostate cancer: 185, 198.82 or 236.5
- Spondylolysis: 738.4, 756.11, 756.19
- Facet arthropathy: 716.9

4. TUMOR LOCALIZATION - Coverage has been provided effective 7/1/90 for the following:

Clinical Indications:

To differentiate between residual lymphoma and necrotic tumor in the chest, abdomen and brain.

ICD.9.CM Code(s):

- Hodgkin's disease: 201.00 - 201.98 or non-Hodgkin's lymphoma: 202.80 - 202.98 (when Gallium is used).
- Colon cancer: 153.0 - 153.8, 197.5 or cancer of ovary: 183.0, 198.6 (when Oncoscint is used).
- Cancer of brain: 191.0 - 191.9, 198.89 (when Thallium - 201 or Tc - 99m sestamibi [Cardiolite] is used).

5. LIVER IMAGING - Coverage has been provided effective 7/1/90 for the following:

- Imaging with labeled red blood cells (RBCs) for the evaluation of hemangioma.

ICD.9.CM Code:

- Hemangioma: 228.04

6. KIDNEY IMAGING - Effective 7/1/90 and after:

Clinical Indications:

For the delineation of cortical function primarily in children.

Utilization Guidelines:

Claims for KIDNEY IMAGING will be reviewed for medical necessity by medical review staff.

ICD.9.CM Code(s):

- Pyelonephritis, chronic 590.0, acute 590.1, unspecified 590.80, 590.9

Billing/Processing Instructions:

1. Benefits are available for either PLANAR imaging or SPECT imaging
2. Bill the appropriate CPT code for the imaging procedure. Effective 1/1/94 and after, use HCPCS code A4641 to bill for supplies for radiological procedures. Use CPT code 78990 - provision of diagnostic radionuclide(s) to bill for these supplies for services rendered prior to 1/1/94. The supply/provision of radionuclide(s) can be reimbursed under Medicare Part B only when the procedure is performed in the office.

EMC claims: Indicate the name of the radiopharmaceutical and the actual invoice price in the narrative field.

Paper claims: A copy of the manufacturer's invoice must be attached to the claim.

3. Indicate the appropriate ICD.9.CM diagnosis code(s) as shown in each section of this policy.


Barry S. Gold MD.

Approved by:

Barry S. Gold, M.D., F.A.C.P.
Medical Director

Provider Notification:

- April 1, 1994 draft policy to Carrier Advisory Committee (CAC)
- Final Policy guidelines to CAC members 5/20/94



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BLUECROSS BLUESHIELD OF MARYLAND

*Minutes of the Carrier Advisory Committee (CAC) Meeting
June 29, 1994*

The meeting was chaired by:

Barry S. Gold, M.D., Medical Director
Joseph Berkow, M.D., Co-Chair

In attendance from the Medicare Contractor were the following:

Mary Anne Heckwolf, Vice President, Medicare Operations
Helene Shugart, Director, Medicare Carrier Operations
M. Elizabeth Krakowski, R.N., Medical Policy Coordinator
Edith Sunderland, Professional Relations
John Wetherington, Professional Relations
Teresa Makowski, R.N., Medical Review

In attendance from the Health Care Financing Administration (HCFA) was the following:

Carol Messick

▼ **Welcome/introduction**

The meeting was brought to order at approximately 6:30 p.m. Opening remarks were made by Dr. Gold. Dr. Gold welcomed the committee members and stated that everyone by now should be aware that BlueCross BlueShield of Maryland would no longer be the contractor for Medicare B claims in the State of Maryland. He then introduced Mary Anne Heckwolf, Vice President, Medicare Operations, to present an update on the transition.

▼ **Transition update**

Mary Anne Heckwolf stated that at the end of May, BlueCross BlueShield of Maryland announced we would not renew the contract to administer the Part B Claims/Service Operation in the State of Maryland. The decision was based on financial reasons:

Maryland is a small contractor consisting of 8 million claims, typical medium sized operations ran around 20-25 million. The infrastructure needed to run would be the same whether small or large, but being a small contractor causes the costs to be higher.

▼ **Transition update (continued)**

BlueCross BlueShield of Texas has been chosen by HCFA to administer the contract in Maryland. Texas processes

approximately 32 million claims using the EDS system, which is used by 8 other contractors for a total of 40 million claims.

BlueCross BlueShield of Texas converted their system 4/1/93 and did so flawlessly. They received a 100% score for their contractor performance review.

The two plans are working together to make this a seamless transition for the providers and beneficiaries. The conversion is planned for 1/1/95. Providers will be kept advised on any changes you may need to be aware of as they are appropriate to disseminate.

Texas does plan to remain in the 20 mile radius of the present location. They will hire between 120-185 employees. They plan to keep the medical policies as they are currently in place.

The HCFA is working towards the Medicare Transaction System (MTS) which will be implemented 1997-1998.

▼ **Med Chi transition role**

Ms. Rose Matricciani, R.N., J.D., Executive Director of Med Chi for the State of Maryland, addressed the group on Med Chi's role in the transition. Ms. Matricciani indicated that she had been working with the HCFA regarding the transition and the importance of not having the providers reimbursements disrupted. She stressed that Med Chi supported the role of a local presence to the HCFA.

Ms. Matricciani stated that at a recent AMA conference, she spoke with several Texas physicians who were generally pleased with the Medicare operations in Texas.

▼ **Medicare program updates**

Edith Sunderland, Professional Relations, presented updates on the following:

Transrectal Ultrasound of the Prostate
New Bundled Codes
Prolonged Care Codes
UPIN Numbers for All Providers

Written updates were provided at the meeting.

▼ **Medical policy issues**

Dr. Gold commented on the need for CAC members to share the new policy information and information obtained during CAC meetings with other members of their respective specialty societies.

The following policies were issued to CAC members:

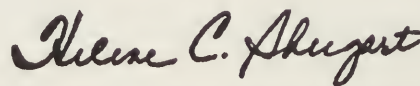
- Colony stimulating factor (final)
- Contigen (national policy)
- Long-term EKG monitoring (draft)
- Upper GI endoscopy (revision)
- Chemotherapeutic drug coverage (revision)

▼ *Questions and answers*

There were no specific questions proposed at this point in the agenda.

▼ *The meeting adjourned at approximately 7:10 p.m.*

Respectfully submitted by:



Helene C. Shugart

Director, Medicare Carrier Operations

PENNSYLVANIA BLUESHIELD

Carrier Advisory Committee, Washington, DC Metropolitan Area

June 14, 1994

The quarterly meeting of the Carrier Advisory Committee (CAC) was held at the McLean Hilton in McLean, Virginia.

Present:

Alexandria Medical Society - Antonio Longo, M.D., Thomas Smirniotopoulos, M.D.; Allergy - Isaac Weiszer, M.D.; Anesthesia - Robert Barth, M.D.; Arlington Agency on Aging - Ruth Reily; Arlington County Medical Society - John Nowell, M.D., Phillip Rodilosso, M.D., Christopher Torres; Cochairman - William Mullins, M.D.; Delmarva Foundation for Medical Care - Harold Weiss, M.D.; D.C. Office on Aging - Esther Robbins, Eleanor Schwartz; Fairfax Area Commission on Aging - Frank Green, Ann McCloud; Gastroenterology - George Bolen, M.D.; General Surgery - Eugene Russo, M.D.; Health Care Financing Administration - Sue Ambruch; Hematology - Thomas Bensinger, M.D.; Medical Society of D.C. - Barbara Allen, David Sniezek, M.D.; Neurology - Benjamin Frishberg, M.D.; Ophthalmology - John Millwater, M.D.; Optometry - Christopher Renner, O.D.; Pathology - James Sundeen, M.D.; Plastic Surgery - Ivens LeFlore, M.D.; Podiatry - James Christina, D.P.M., Harold Glickman, D.P.M., Stephen Pribut, D.P.M.; Prince George's County Medical Society - Bert Weisbaum, M.D.; Radiation Oncology - Pamela McClain M.D.; Rheumatology - Joseph Laukaitis, M.D.; Virginia Society of Internal Medicine - Lawrence Clark, M.D.; Pennsylvania Blue Shield - Gerald Godfrey, Paul Legendre, Brent O'Connell, M.D.

▼ *Call to order*

Dr. Mullins called the meeting to order.

▼ *Review and approval of minutes of last meeting*

Minutes were approved as submitted.

▼ *Old business*

A. Case management - phone calls to patients

Dr. Mullins informed the members that the Health Care Financing Administration (HCFA) planned to enhance compensation for patient telephone calls by increasing the relative value units assigned to the office visit procedure codes. While welcoming this measure as a generally positive shift in direction, Drs. Rodilosso and Smirniotopoulos noted that it provided only partial redress for the multiple deficiencies of case management policy. As explained by Dr. Clark during the course of earlier CAC meetings, an equitable policy would have to reflect a greater recognition of the often considerable amounts of time spent in telephone communication with visiting nurse and nursing home personnel. Consideration should also be given to the demands placed on physicians for documentation of the necessity for durable medical equipment. In evaluating these matters, HCFA would err if it concluded that they did not constitute genuine medical management.

Dr. O'Connell stated that physicians could expect some moderately broad changes in the area of case management. However, these would not include a facility for the direct billing of telephone calls or other non face to face services. As in the past, compensation for these services would continue to be bundled with payments for office visits. Dr. Mullins added that HCFA continued to harbor concerns about the potential of case management for abuse and about its authenticity as medical care.

B. Automated multichannel laboratory testing

As outlined by Dr. O'Connell, Pennsylvania Blue Shield (PBS) policy vis a vis automated multichannel tests consists of two essential elements—maximum inclusion and medical necessity. In brief, the former, in effect for many years as a cost control measure, classifies and pays as multichannel any test which is capable of being performed on multichannel equipment irrespective of the actual method employed or manner billed. The policy is activated by the performance of two or more pertinent tests on the same day.

Concerning the second element, PBS is in the process of developing techniques for the identification of tests which exceed the medical needs of a patient in a given set of circumstances, e.g. 80015 performed in lieu of a more appropriate 80010. Consequently, it will be incumbent upon physicians to make judicious selections among the available levels of testing. Thus far, development has progressed to the point of establishing an automatic exclusion for multichannel suitable tests performed beyond the maximum (19) that can be described under current coding convention, i.e. 80019. Incremental tests in excess of 19 will be denied. The detection of significant fraud in the billings of some national laboratories has provided the impetus for these initiatives.

In elaborating on the above, Dr. Sundeen referred to the unfair burdens that it placed on laboratories. Although excessive or inappropriate tests are ordered by attending physicians, the financial effects of denials are borne by laboratories, most of which do not engage in fraudulent activities. The majority of the problems associated with multichannel testing could be resolved through the expedient of discrete panels of tests based on relevant diagnoses. Such would also provide a safeguard for the value of a physician's time by eliminating the need to prescribe individual tests. As a general proposition, all should bear in mind that the attention being focused on laboratories is at least partially motivated by a desire on the part of HCFA and others to create divisions within the physician community.

Replying to Dr. Mullins, Dr. O'Connell stated that PBS could, in the absence of national guidelines, change the composition of individual multichannel procedure codes. Drs. Rodilosso and Smirniotopoulos were informed that tests need not be individually identified on claims and that the submittal of a claim(s) for two panels of tests on one day would result in the rejection of one.

A Special Bulletin of April 14, 1994 which announced additions to the list of tests subject to multichannel guidelines was based on advice from consultants and a lack of objections from CACs to circulated drafts. Its subsequent

revocation resulted from commentary provided by certain national laboratories. A member suggested that such swings in policy might be avoided in the future by allowing more time for the development of consensus.

C. Concurrent care

As presented by Dr. O'Connell, existing PBS policy with regard to concurrent care will undergo a substantial modification in the near future. The new policy will bring to an end the practice of equating a number of the subspecialties of internal medicine to each other and to the specialty of internal medicine. It will lead to fewer denials of evaluation and management services rendered in an inpatient setting.

In response to Drs. Smirniotopoulos and Rodilosso, Dr. O'Connell confirmed that the revised policy, developed in the wake of a retracted HCFA proposal for national guidelines, will cause a modest reduction in the rate of claims suspended for further review. Dr. Mullins welcomed the achievement of a satisfactory outcome for a long enduring problem.

▼ New business

A. Comparative performance reports

By means of illustrative overhead projections and material contained in the meeting packets, Mr. Godfrey acquainted the members with the background and primary components of the Comparative Performance Report (CPR) program. It is a manifestation of the intent expressed by Congress in the Omnibus Budget Reconciliation Act of 1989 to inform physicians when the frequency of their service significantly surpasses that of peers. The program is educational and informational in nature and completely divorced from utilization review activities, although both rely on statistics derived from the same data base. Physicians who receive CPRs are not required to respond to the carrier, though they may if so inclined. Still in its formative stages, the final design of the program may yet be shaped by recommendations from physicians and other parties.

Criticisms of the proposal were voiced by Drs. Longo, Mullins, Sundeen, LeFlore and others. To summarize:

- Subspecialists will be disproportionately affected by the program. For example, neuropathologists, physicians rendering home visits, and those concentrating on EMGs will receive unmerited and meaningless CPRs.
- CPRs resemble initial HCFA efforts to assess lab proficiency. Final result was CLIA legislation.
- Although promoted as purely educational, CPRs will inevitably have a negative psychological effect on physicians.

- Sample of .6% too small to be of consequence.
- Any conclusion drawn from data will be highly prone to error.
- Entire program suffers from a failure to recognize the complexities of individual practices.
- Viewed in totality, the CPR program gives the appearance of being a mandate for a mindless exercise.

Recommendations proffered by Drs. Longo, Weisbaum, Rodilosso, Barth, LeFlore and others were as follows:

- Increase notifications to include a more meaningful number of physicians.
- Send CPRs to the top .6% physicians in each specialty.
- Provide all physicians with on line access to their personal CPR related data.
- Measure only the 10 most commonly performed procedures in each specialty.
- Incorporate editorial comments or a disclaimer in the CPR to the effect that it does not provide a true or complete picture of an individual practice.

On a motion from Dr. LeFlore, the CAC accepted a resolution which declares, "CPRs should incorporate or be accompanied by a disclaimer which states that the report may not be accurate and must not be used for disciplinary purposes." The motion was seconded and unanimously approved.

Mr. Godfrey commented on the similarity between the sentiments and reactions of the D.C. CAC and those registered by other CACs. Ms. Ambruch emphasized HCFA's guiding philosophy of the CPR as a cooperative and educational project.

B. Report on Carrier medical directors meetings

Dr. O'Connell apprised the CAC of topics recently considered by the Carrier Medical Directors.

- *Lung transplantation.* Procedure has not been assigned to a diagnosis related group. Hospitals are paid approximately \$15,000 per procedure, causing some a yearly financial loss of \$160,000. Pertinent issues are under study.
- *Foot care.* Changes in the findings used as support for routine foot care services have been proposed.
- *Cardiac rehabilitation programs.* Approved for treatment of patients having undergone bypass surgery or experienced myocardial infarction within the previous six months. Angioplasty specifically excluded as a covered part of a program.
- *Transjugular portacaval anastomosis.* Classified as investigational.
- *Infusion therapy.* Should be billed using codes 96412, 90780, and 90781. Codes 90780 and 90782 are to be

used in conjunction with pre-chemotherapy hydration services.

- *Contigen.* Endoscopic injections billed under code 51715. Substance will probably be paid by PBS rather than the regional carrier. A new code, Q0134, will be assigned. Preadministration skin test to be billed as code 95028. Coverage rules for contigen will probably become national policy.
- *Protein A (Prosorba) immunoadsorption.* Investigational, but payment possible on an individual consideration basis.
- *Flow cytometry.* Covered under codes 88180 and 88182.
- *Radiographic absorbtometry.* National policy extended coverage to 78350 and 78351. Dexa and CT still considered investigational.
- *PSA.* Coverage currently limited to patients having symptoms. Will soon be covered as a tumor marker.
- *Oncoscint.* Covered when billed as code A4641.
- *Ultrafast CT and MRI.* Covered but not separately payable.
- *MRA.* Investigational.
- *Screening mammograms.* Redefined by HCFA as encompassing four views instead of two. Consultation can probably be billed also.
- *Pulmonary function testing.* Use code 94060 to bill when both services described by codes 94010 and 94375 are performed.
- *ESRD capitation.* Payment includes reimbursement for nerve conduction velocity, bone survey, and bone density tests as well as the professional component of doppler studies. Unknown at this time whether this clarification will result in recoupment of prior itemized payments. A member noted that HCFA is evaluating the feasibility of establishing relative value units for ESRD capitation.
- *HIP arthroscopy.* Considered to be investigational.
- *Endoscopic ultrasound.* Investigational, but may soon transition to covered.

C. Proposed medical policy changes

Dr. O'Connell directed the attention of the CAC to the proposals sent as attachments to the minutes. The mammography guidelines elicited comments from several members. Discussion centered primarily on the medical paradox of a policy which covered screenings at briefer intervals for younger women than older. Ms. Ambruch noted that biennial screenings for women of 65 years of age or more was a matter of national policy. Dr. Mullins requested that this topic appear on the agenda for the next

meeting in order that it might receive a more thorough examination.

Mr. Godfrey reminded the attendees of the need to respond to proposed medical policy changes by the indicated deadlines. Dr. O'Connell added that deadlines are always extended to the date of the last CAC meeting of a quarter.

D. Multiple surgical procedures same day

Dr. Russo, with the support of Dr. LeFlore, remarked on the ineffectiveness and multiplicity of modifiers associated with the billing of surgical procedures. Far too often, payment can be received only upon appeal. He was advised by Mr. Godfrey and Ms. Ambruch to forward exemplary cases to Mr. Godfrey in Camp Hill.

Drs. Smirniotopoulos and Russo also commented on the apparent incompatibility of some CPT-4 codes with the PBS claims processing system and a related problem of codes employed by Medicare which do not appear in the CPT-4 Manual. As above, examples were requested. Ms. Ambruch noted that these perceptions may be at least partially attributable to the temporary use of HCPCS codes by the carrier as an interim measure prior to the issuance of apt CPT-4 codes.

E. Request from Mississippi Carrier Advisory Committee

After reviewing a resolution from the Mississippi CAC on the subject of language used in Explanation of Benefits forms, the Committee moved to support the position adopted by its correspondent organization. It could not be determined whether the D.C. CAC would have an opportunity to preview any new language which might spring from the Mississippi resolution.

F. Packaged price arrangements

Dr. Barth spoke for many in expressing uncertainty about the proper relationship of Medicare to coverages provided by managed care companies, both in primary and secondary payer situations. There is a particular concern about potential conflicts between the legal requirements of Medicare and some of the innovative contractual arrangements imposed by managed care companies. For example, it is difficult to adapt traditional concepts of deductible, coinsurance, and fee schedule to systems which make one payment for the first 100 of its subscribers treated. At the request of Dr. Smirniotopoulos, Mr. Godfrey agreed to provide guidance at the next CAC meeting.

G. Home IV therapy

Drs. Weisbaum and Bensinger addressed the apparent contradictions inherent in the rules governing payment for

this service. They cited cases of patients hospitalized for the sole purpose of rendering a treatment which could have been administered as safely and effectively in the home. Conversely, physicians who admit such patients place themselves at risk of being characterized as overutilizers of hospital resources. As a final note of incongruence, physicians are paid less than nurses for providing an equivalent service.

Mr. Godfrey traced the problems enumerated by the physicians to the "incident to" rule of Medicare Part B which, with few exceptions, permits payment to physicians only for services which they have personally supervised. Dr. O'Connell stressed that any consideration of benefits for home IV therapy must take into account the very costly nature of the service. He will place the entire matter on the agenda of the Carrier Medical Directors.

H. Any willing provider issues

The membership expressed its opposition to the growing tendency of Health Maintenance Organizations (HMO) to limit participation of interested and qualified physicians through the establishment of arbitrary acceptance criteria. Some felt that it was a violation of HCFA policy to do so. Acting upon its views, the Committee accepted a motion stating, "HMOs should be required to enroll any physician who is willing to abide by their fee structures and other objective rules." Dr. Mullins was instructed to notify the appropriate political officials of the Committee's unanimously adopted resolution.

I. Subacute care reimbursement

Dr. Smirniotopoulos alluded to an escalation in admissions of beneficiaries to sub-acute care hospitals. Care provided by physicians in such institutions is of a markedly higher level than that furnished in skilled nursing facilities. However, because of a lack of codes specific to this type of facility, physicians must report their services therein by means of the inadequate nursing home codes.

In response, Ms. Ambruch stated that she was not aware of the existence of any current activity which was directed towards the development of sub-acute care codes. Dr. Smirniotopoulos requested that inquiries be conducted on this matter and that pertinent findings be provided to the CAC.

J. Prostate specific antigen

Reminiscent of some of the problems uncovered during the course of the discussion on multichannel testing, laboratories were once again burdened with the impractical responsibility of providing justification, i.e. diagnosis, for a service ordered by an attending physician. Dr. O'Connell

explained that this turn of events resulted from the operative philosophy of HCFA that the entity to be paid is held responsible for furnishing all information needed for the proper adjudication of a relevant claim.

On a motion from Dr. Sundeen, the CAC adopted a resolution stating, "Payments for PSA should not be subject to unrealistic diagnosis reporting requirements."

K. Laboratory testing guidelines for patients receiving antineoplastic chemotherapy for cancer

In response to an observation that the guidelines for payment of antineoplastic testing printed on page 11 of the Special Notice of April 14, 1994 lacked clarity, Dr. O'Connell remarked that it would be unlikely that denials would occur in this area.

L. Nominations for new cochairman

Drs. Mullins and Clark were nominated as candidates to occupy the position of cochairman during the next year of operations. Ballots will be cast at the next meeting.

M. Physician satisfaction survey

Mr. Godfrey informed the members of the impending release of a survey which was designed by HCFA as a means for measuring physician satisfaction with carriers and the Medicare Program in general. This initiative will build on a similar study conducted earlier by PBS.

▼ **Open discussion**

A. Ventilation management

In a reply to Dr. Smirniotopoulos, Ms. Ambruch stated that HCFA was not contemplating a change in its recent decision to bundle ventilatory management.

B. Correspondence reviews

Four sets of 10 pairs each of typical examples of written Medicare inquiries and responses were distributed by Mr. Godfrey for review by the EOB subcommittee of the CAC. Reply to Patrick Kiley of PBS by July 1 was requested.

C. Health professional shortage areas

The CAC was advised by Mr. Godfrey of a continuation in the relatively high rate of misuse of the QB and QU modifiers used to designate services as rendered in a HPSA (a formally recognized medically underserved census tract). Consequently, many physicians were being subjected to recoupments of the 10% premiums associated with these services. To avoid such occurrences, physicians must refer to appropriate PBS publications for the identity of HPSA census tracts and make use of the QB and QU modifiers only for services actually provided within the boundaries of eligible tracts.

D. Modifiers

Mr. Godfrey directed the attention of the members to a multi-page listing of modifiers enclosed in the meeting packets. The listing also appeared in the June, 1994 Medicare Report in the form of an index.

▼ **Adjournment**

Dr. Mullins adjourned the meeting.

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The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

- Pain Management
- Patient Education
- Patients with Handicapping Conditions

Papers may be original research, literature reviews, brief reports, case histories accompanied by a brief overview/summary of the relevant literature, or well-documented opinions about future trends. Deadline for submissions is February 15, 1995.

All submissions should conform to *Maryland Medical Journal* requirements. For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor, 1211 Cathedral Street, Baltimore, MD 21201; 410-539-0872 or 1-800-492-1056; FAX 410-547-0915.



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The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

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All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated.

Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
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- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

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Miscellaneous meetings

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| Network approach to provision of health care , sponsored by the Baltimore City Medical Society at the Good Samaritan Hospital. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. | Oct. 6 |
| Ophthalmil oncology and ocuplastics , sponsored by the Greater Baltimore Medical Center at GBMC in Baltimore, MD. 5 Cat 1 CME credits. Fee: \$95.00. Info: 410-828-3670. | Oct. 7 |
| Hematology board review course , sponsored by the George Washington University Medical Center, the Ritz-Carlton, in Pentagon City, VA. Info: Maria Gorrick, 202-994-4285. | Oct. 11-15 |
| The health care professional and grieving people: Clinical interventions , sponsored by the Steven Daniel Jeffreys Foundation and Taylor Manor Hospital at Taylor Manor Hospital in Ellicott City, MD. 4 Cat 1 AMA/PRA credits. Info: 410-465-3322. | Oct. 14 |
| Colorectal surgery for the practitioner , sponsored by the Greater Baltimore Medical Center at GBMC in Baltimore, MD. 4 Cat 1 CME credits. Fee: \$50.00. Info: 410-828-3670. | Oct. 15 |
| Second annual gynecology CME course , at the Plaza Hotel in NY, 13.5 Cat 1 AMA credits. Fee: \$495/physicians; \$295/physicians-in-training and allied health professionals. Info: Svetlana Lisanti, 201-385-8080. | Oct. 15-17 |
| Annual business meeting , sponsored by the Baltimore City Medical Society at UMMS Davidge Hall. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. | Nov. 3 |
| Interface: Medicine Psychiatry , sponsored by Saint Joseph Hospital at the Noppenberger Auditorium, Saint Joseph Hospital, Towson, MD. 6 Cat 1 AMA/PRA/AAFP credits. Fee: \$45/physicians; \$45/psychologists; \$25/house staff, nurses, allied health professionals. Info: Patricia Fuchsluger 410-337-1501. | Nov. 5 |
| Evaluation of shoulder dysfunction and pain , sponsored by the Omni Physical Therapy and Allsports Therapy Center in conjunction with Anne Arundel Medical Center, to be held at the Comfort Inn in Bowie, MD. 3 Cat 1 AMA credits. Fee: \$50.00. Info: 301-474-6505. | Nov. 12 |
| Recent advances in male infertility , sponsored by the Greater Baltimore Medical Center at GBMC in Baltimore, MD. 5.5 Cat 1 CME credits. Fee: \$40.00. Info: 410-828-3670. | Dec. 5 |
| Third world congress on stress, trauma and coping in the emergency services professions , at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311. | April 19-23 |
| Clinical innovations in OB/GYN ultrasound , sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine, at the Lowes L'Enfant Plaza in Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by ACOB/GYN. Info: Ann Boehme 516-561-4223. | April 22-23 |

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month, 8:00-9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, Maryland. Info: 301-279-6115.

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| Imaging update | Oct. 6 |
| Tumor conference | Oct. 13 |

Shady Grove Adventist Hospital (continued)

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| Pancreatic cancer—New therapies | Oct. 20 |
| Boundary issues | Oct. 27 |
| Pediatric urology | Nov. 3 |
| Tumor conference | Nov. 10 |
| OB/GYN topic | Dec. 1 |
| Tumor conference | Dec. 8 |
| Infectious disease topic | Dec. 15 |

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

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| Pediatrics for practitioner update '94. 14 Cat 1 AMA credits. Fee: \$290/physicians; \$190/residents*, retired physicians, allied health professionals, fellows* (with letter). | Sept. 29–30 |
| 20th anniversary: Annual topics in gastroenterology and liver disease. Cat 1 AMA credits. Fee: \$495 physicians; \$250 residents and fellows (with letter from department chairperson verifying status). | Oct. 5–7 |
| Eighth annual core content of emergency medicine: A comprehensive review, at the Marriott Hotel, BWI Airport, Baltimore, MD. 76.5 Cat 1 AMA credits, 3 Cat 1 AMA credits for optional wound closure workshop, 74.5 ACEP Cat 1 credits, 70.75 AAFP prescribed hours. Fee: \$1,000/physicians (\$1,100 after Sept. 1); \$800/residents/fellows (\$1,100 after Sept. 1). | Oct. 6–13 |
| Flexible sigmoidoscopy | Oct. 8 |
| 36th annual Emil Novak memorial course: Gynecology, gynecological pathology, endocrinology and high risk obstetrics and first annual Richard W. Telinde lecture. | Oct. 15–20 |
| Diabetic retinopathy and venous occlusive disease. | Oct. 21–22 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA credits available. Fee: \$500 lectures, \$500 each additional lab, \$200 lectures for fellows and allied health professionals. | Oct. 24–26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27–30 |
| Update on sinusitis for the practitioner. | Oct. 28 |
| Advanced pediatric life support courses, 20 Cat 1 AMA credits. Fee: \$525. | Oct. 31–Nov. 2; June 12–14 |
| Progress in pediatrics, 11 Cat 1 AMA credits. | Nov. 4–5 |
| The first century of blastomycosis-fungal infections in immunocompromised hosts, at the Stouffer Harborplace Hotel, Baltimore, MD. 10 Cat 1 AMA credits. Fee: \$150.00/physicians; \$75.00/residents. Single day fee available. | Nov. 12–13 |

The Johns Hopkins Medical Institutions

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| Advances in pediatric nutrition , at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: \$200/physicians and allied health professionals; \$150/ residents and fellows. | Nov. 14–16 |
| Ophthalmic update for the medical practitioner | Nov. 18 |
| Fifth annual neurology for the primary practitioner at the Harbor Court Hotel, Baltimore, MD. 6 Cat 1 AMA credits. | Dec. 3 |
| Seventh annual Wilmer Institute current concepts in ophthalmology , 20 Cat 1 AMA credits. | Dec. 8–10 |
| Memory and reality: Reconciliation. Scientific, clinical and legal issues of false memory syndrome , at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: Postmarked before Oct. 1: \$300/professionals; \$125 families (includes 2 family members); postmarked after Oct. 1: \$400/professionals; \$275 families (in- cludes 2 family members). | Dec. 9–11 |
| Basic comprehensive endoscopic sinus surgery , Cat 1 AMA credits available. \$850/labs and lectures; \$325/lectures only. | Jan. 12 |
| Advanced comprehensive endoscopic sinus surgery , Cat 1 AMA credits available. \$1400/ labs and lectures; \$495/lectures only. | Jan. 13–14 |
| 1995 Update in the management of age-related macular degeneration , Cat 1 AMA credits pending. Fee: \$225/physicians; \$125/residents, fellows and allied health profes- sionals. | Jan. 21 |
| 36th Annual postgraduate institute for pathologists in clinical cytopathology , 136 Cat 1 AMA credits. Course A (Home Study) Course B (Johns Hopkins Medical Institutions) | Feb–March April 3–14 |

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Johns Hopkins sports medicine grand rounds.** Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

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| Endocrinology update for the practicing physician 1994 , at Harrisons Pier 5, Baltimore, MD. 10 Cat 1 AMA credits. Fee: \$175/physicians; \$100/residents and fellows. Info: Dorothy Taylor 410-328-2515. | Oct. 7-8 |
| Infant mortality and sudden infant death syndrome: Current research and clinical implications , at the Holiday Inn Crowne Plaza Hotel in Rockville, MD. 19 Cat 2 AMA credits. Fee: \$155 plus \$25. Info: Jody Schaefer 410-706-5062. | Oct. 13-15 |
| Managing depression and related disorders in the ambulatory setting , at the Stouffer Harborplace Hotel in Baltimore, MD. Info: 410-706-3957. | Oct. 29 |
| Advances in epilepsy , at the Harbor Court Hotel in Baltimore, MD. 5.5 Cat 1 AMA credits. Fee: \$35.00. Info: Catherine Bowers 410-828-7700. | Nov. 14 |
| R. Adams Cowley 16th annual national trauma symposium , at the Hyatt Regency, in Baltimore, MD. Info: 410-328-2399. | Nov. 16-20 |
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September, 1994

Selected Communicable Diseases in Maryland in 1993 (Continued)

HAEMOPHILUS (64) INFLUENZAE DISEASE 1.3/100,000 (U.S. 0.5/100,000)

The trend of invasive *Haemophilus influenzae* disease from 1984 to 1993 is illustrated in Figure 3. Active surveillance for invasive *H. influenzae* disease in hospitals and medical laboratories began in November, 1991. The number of reported cases from 1989 through 1993 and by jurisdiction is shown in Table 1 (see August, 1994 issue). In 1993, more than 40% of all cases occurred in the Baltimore metropolitan area, followed by the Montgomery - Prince George's area with 27% of the cases. The highest rates per 100,000 population were noted in Talbot (6.4) and Carroll (3.1) counties, and in Baltimore City (2.2).

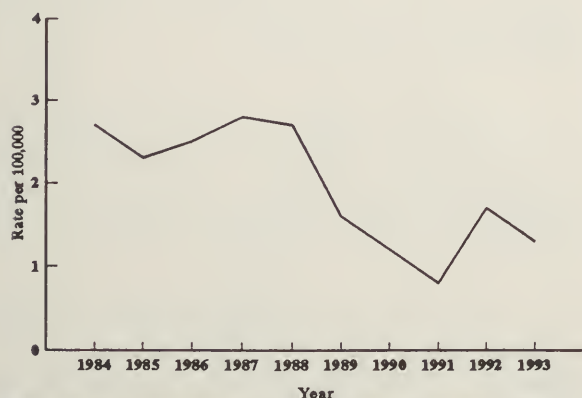


Fig 3. *Haemophilus influenzae* invasive disease. Incidence, Maryland, 1984-1993.

The male to female ratio was 1.3:1.0. The ratio of whites to blacks was 1.9:1.0; one case was Asian, and the race of 3 cases was unknown. Ages ranged from 1 day to 98 years (median 33.5 years). Figure 4 presents the number of cases from 1987 to 1993 by age group and illustrates the continued decline of *Haemophilus influenzae* disease among children. In 1993, 42 (66%) of the reported cases were 20 years of age or older. The increase of adult cases since 1991 is probably due to enhanced reporting through active surveillance.

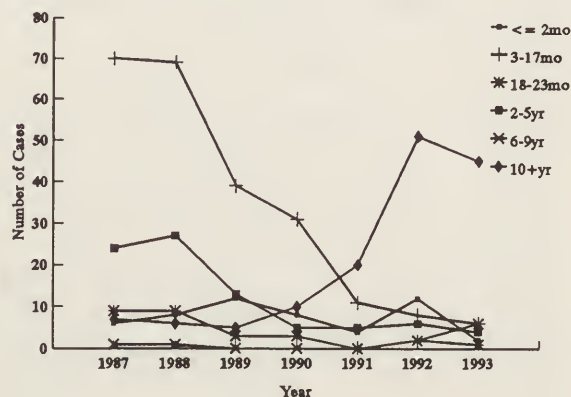


Fig 4. *Haemophilus influenzae* disease. Cases reported by age group, Maryland, 1987-1993.

H. influenzae caused the following types of illness: 33 (52%) primary bacteremia, 16 (25%) pneumonia; 7 (11%) meningitis, 2 (3%) bronchitis and pharyngitis, 1 (2%) mediastinitis, and 5 (8%) other infections.

Seven patients died for a case fatality rate of 14%, 44 survived, and the outcome for 13 cases was unknown.

H. influenzae isolated from 46 patients showed that 15 (33%) were resistant to ampicillin (the percentages in 1990, 1991, and 1992 were, respectively, 57, 32, and 48).

Information on the serotypes was available for 26 cases: 12 (46%) were type b, 11 (42%) were nontypable, and 3 (12%) were other serotypes.

HEPATITIS A (184) 3.7/100,000 (U.S. 8.5/100,000)

The number of cases by jurisdiction is shown in Table 1 (see August 1994 issue). The incidence in 1993 declined from the rate in 1992 (5.2/100,000). The trend of hepatitis A from 1984 to 1993 is illustrated in Figure 5. In 1993, 45% of all cases in Maryland were reported from the Baltimore metropolitan area and Anne Arundel County. The highest rate per 100,000 population was noted in Wicomico County (17.0), followed by the rate in Baltimore City (6.0), and Howard County (4.9). Hepatitis A did not have a seasonal pattern.



Fig 5. Hepatitis (A, B, NANB, and Unspecified). Cases reported, Maryland, 1984-1993.

The male to female ratio was 1.2:1.0. The ratio of whites to blacks was 3.6:1.0; 14 cases were Asian, 8 were other race, and the race of 28 (15%) was not specified. The rate in whites was 3.0/100,000 and the rate in non-whites was 3.6/100,000. The highest rate was noted in non-white males (4.6/100,000), followed by the rate in white males (3.5/100,000). Age and sex-specific rates per 100,000 population are presented in Figure 6. In males the highest incidence per 100,000 population occurred in 20 to 29 (6.1) and 30 to 39 (5.3) year olds; in women the highest rates were noted in age groups 20 to 29 (4.0) and 30 to 39 (4.0) years.

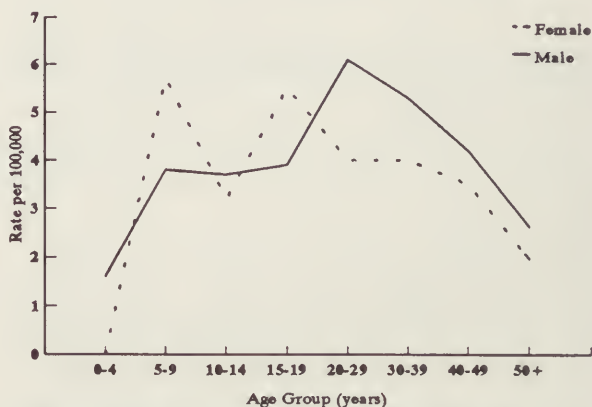


Fig 6. Hepatitis A. Incidence by age group and sex, Maryland, 1993.

Among the 90 cases with known occupation (excluding unemployed, homemakers, etc.), 7 (8%) were food-handlers and 3 (3%) were health care providers.

Of the 78 cases with known workplace, 7 (9%) were working in foodhandling businesses, 4 (5%) in hospitals, 1 (1%) in a nursing home, and 1 (1%) in a child care facility.

A known or suspected source of infection was reported for 63 (34%) of the cases. Of these, 20 (32%) had traveled outside of the U.S.A., 19 (30%) had handled and/or consumed potentially contaminated food, including 4 patients who had eaten raw shellfish, 16 (25%)

had contact with confirmed or suspected hepatitis A case, 3 (5%) had contact with a child or an employee in a nursery or a day care center, 2 (3%) were injectable drug users, 1 (2%) had homosexual exposure, and 3 (3%) had other exposures.

HEPATITIS B (288) 5.9/100,000 (U.S. 4.7/100,000)

The decline of acute hepatitis B which started in 1987 continued through 1993 and was noted in all age groups. The trend in Maryland during the past 10 years is reflected in Figure 5. The number of cases in 1993 by jurisdiction is shown in Table 1 (see August 1994 issue). Baltimore City reported 33% of all cases in the State, for a rate of 13.1 per 100,000 population. The highest incidence was noted in Dorchester County (29.5/100,000).

The male to female ratio was 1.5:1.0. The incidence in males was 7.1/100,000 and the rate in females was 4.6/100,000. The ratio of whites to blacks was 0.8:1.0; 5 cases were Asian, and the race of 63 was not specified. The rate per 100,000 population in non-whites (8.6) was 3 times higher than the rate in whites (2.9). The incidence per 100,000 population by age group and sex is presented in Figure 7. The highest rates were observed in males, 20 to 39, and in females, 15 to 29 years of age.

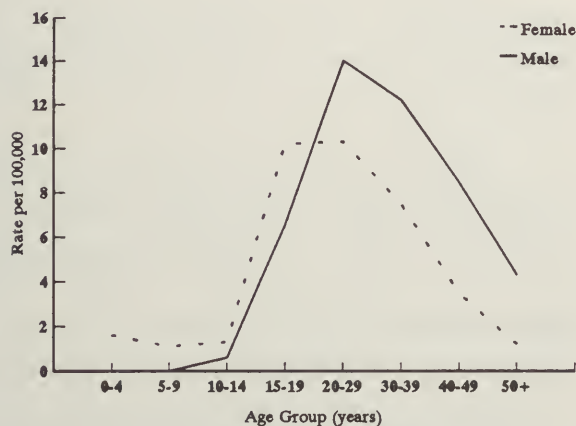


Fig 7. Hepatitis B. Incidence by age group and sex, Maryland, 1993.

Of the 74 (26%) adults with known occupation (excluding retired, unemployed, homemakers, students, etc.), 5 (7%) were health care providers with direct patient contact.

Of the 92 (32%) cases with known workplace, 4 (4%) were working in correctional facilities, 2 (2%) in hospitals, and 1 (1%) in an institution for the mentally/ developmentally disabled.

Information on exposure during the 6 months prior to onset of illness and probable source of infection was available for only 73 (25%) cases. Of these, 26 (36%) admitted drug use (compared to 43% in 1992, 33% in 1991, 31% in 1990, and 47% in 1989), 20 (27%) had heterosexual and unspecified sexual exposure, 9 (12%) had contact with a confirmed or suspected hepatitis B case, 5 (7%) had homosexual exposure, 1 (1%) had perinatal exposure, 1 (1%) had laboratory exposure, 1 (1%) had acupuncture, 1 (1%) had had a tattoo, 1 (1%) had blood transfusion, 1 (1%) had eaten raw shellfish, and 7 (10%) had other exposures.

HEPATITIS NANB (16) 0.3/100,000 (U.S. 2.0/100,000)

The 10 year trend of non-A/non-B (NANB) hepatitis in Maryland is illustrated in Figure 5. The incidence per 100,000 population in 1993 declined from the rates in 1992 (0.6) and 1991 (0.9). The number of cases by jurisdiction in 1993 is shown in Table 1 (see August 1994 issue). The highest rates were noted in Wicomico (6.5/100,000) and Allegany (4.0/100,000) counties.

The male to female ratio was 2.2:1.0. The rates per 100,000 population in males and females were 0.5 and 0.2, respectively. The ratio of whites to blacks was 2.5:1.0. The rate per 100,000 population was 0.3 for both whites and blacks. The youngest patient was 15 years old. Half of the patients were 35 to 49 years of age.

The suspected source of infection during the 6 months prior to onset of illness was reported for 5 (31%) of the cases. Of these 2 (40%) had received blood or blood products by transfusion, 1 (20%) was a kidney dialysis patient, 1 (20%) was an injectable drug user, and 1 (20%) had traveled outside of the U.S.

LEGIONELLOSIS (52) **1.1/100,000 (U.S. 0.5/100,000)**

The reported cases of legionellosis in 1993 increased by 33% from the cases in 1992 (39). The number of cases by jurisdiction is shown in Table 1 (see August, 1994 issue). Almost a quarter (23%) of all cases occurred in Baltimore County. Frederick County (6 cases) had the highest rate (3.6/100,000) in the State. There was preponderance of cases in the summer months - 24 (46%) cases occurred in June through September.

The male to female ratio was 0.9:1.0. The incidence per 100,000 population in females (1.1) was slightly higher than the rate in males (1.0). The ratio of whites to non-whites was 3.6:1.0; the race of 6 cases was unknown. Ages ranged from 16 to 91 years (median 60 years); the ages of 3 persons were unknown. The incidence per 100,000 population by age group and sex is shown in Figure 8.

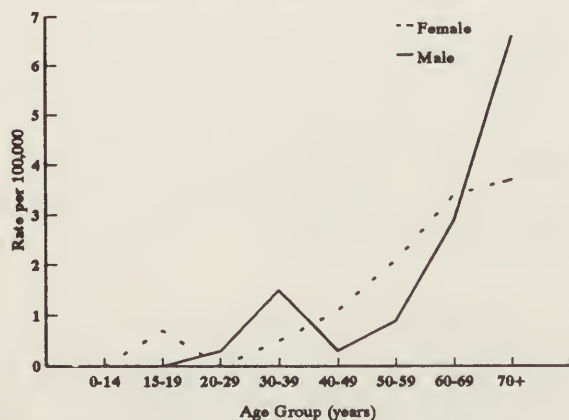


Fig 8. Legionellosis. Incidence by age group and sex, Maryland, 1993.

Information on possible source of exposure in the 2 weeks before onset of illness and/or underlying medical conditions was

available for 22 (42%) cases. Of these, 18 (82%) were smokers of more than 10 cigarettes per day; of the smokers, 2 were undergoing systemic corticosteroid treatment, 1 had leukemia, 1 - melanoma, 1 - diabetes, and 1 - cancer of unknown kind. Among the 4 (18%) non-smokers, there were 2 cases undergoing systemic corticosteroid treatment, 1 was undergoing other immune-suppressant treatment, and 1 had diabetes. Eight (15%) patients had indicated no possible source of infection or predisposing factor(s), and for 22 (42%) information was not available.

Six deaths occurred for a case fatality rate of 14%; the outcome for 9 (17%) patients was unknown.

LYME DISEASE (207) **4.3/100,000 (U.S. 3.0/100,000)**

In 1993, Lyme disease increased by 12% from 1992 (185 cases). The trend in the past 7 years is shown in Figure 9. In 1993 every county and Baltimore City reported cases. Garrett County, with no cases until 1992, reported 1 case in 1993. The number of cases by jurisdiction is shown in Table 1 (see August, 1994 issue). The highest rates per 100,000 population were noted in Queen Anne's (49.0), Kent (38.5), Caroline (28.2), and Talbot (28.0) counties.

Seventy-seven percent of all cases had onset of illness in April through September; the peak incidence was in June (56 cases) and July (44 cases).

The male to female ratio was 1.3:1.0. The ratio of whites to non-whites was 8.0:1.0, the race of 14 cases was unknown. Ages ranged from 2 to 86 years (median 33 years). The highest rates per 100,000 population occurred in age groups 5 to 9 (9.7) and 50 to 59 (6.0) years.

A definite tick bite prior to onset of illness was reported by 77 (37%) cases; 84 (41%) had no known tick exposure, and for 46

(22%) there was no exposure information available.

Of the 207 cases, 125 (60%) had erythema migrans, 55 (27%) had arthritis, 27 (13%) had Bell's palsy, 13 (3%) had radiculoneuropathy, 7 (3%) had cardiac symptoms, 5 (2%) had lymphocytic meningitis, and 4 (2%) had encephalitis. The percent of cases reported with neurologic manifestations (Bell's palsy, radiculoneuropathy, lymphocytic meningitis, and encephalitis) has increased from 9% in 1990 to 21% in 1993 (Figure 10).

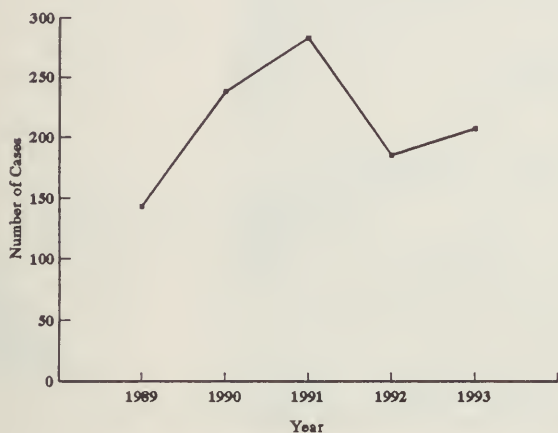


Fig 9. Lyme disease. Cases reported, Maryland, 1989-1993.

MALARIA (57)

1.2/100,000 (U.S. 0.5/100,000)

The number of reported malaria cases in the past 5 years and the cases by jurisdiction in 1993 are shown in Table 1 (see August, 1994 issue). Prince George's County had the highest incidence per 100,000 population (2.9), followed by the rate in Montgomery County (2.5) and Howard (2.5) counties.

The male to female ratio was 1.5:1.0. The ratio of whites to non-whites was 0.1:1.0. Ages ranged from 2 to 70 years (median 31 years). Twenty-four percent of the cases were 30 to 39 years of age; the highest incidence per 100,000 population (3.8) was in age group 15 to

19 years.

All malaria cases were imported. *Plasmodium falciparum* and *P. ovale* were acquired in West Africa, *P. malariae* in East Africa, and *P. vivax* in Asia, West Africa, and Central America.

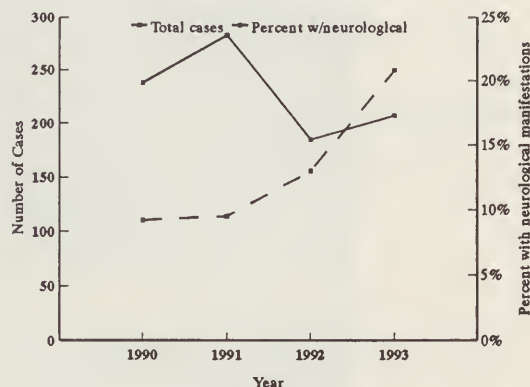


Fig 10. Lyme disease. Total cases reported and percent of cases with neurological manifestations, Maryland, 1990-1993.



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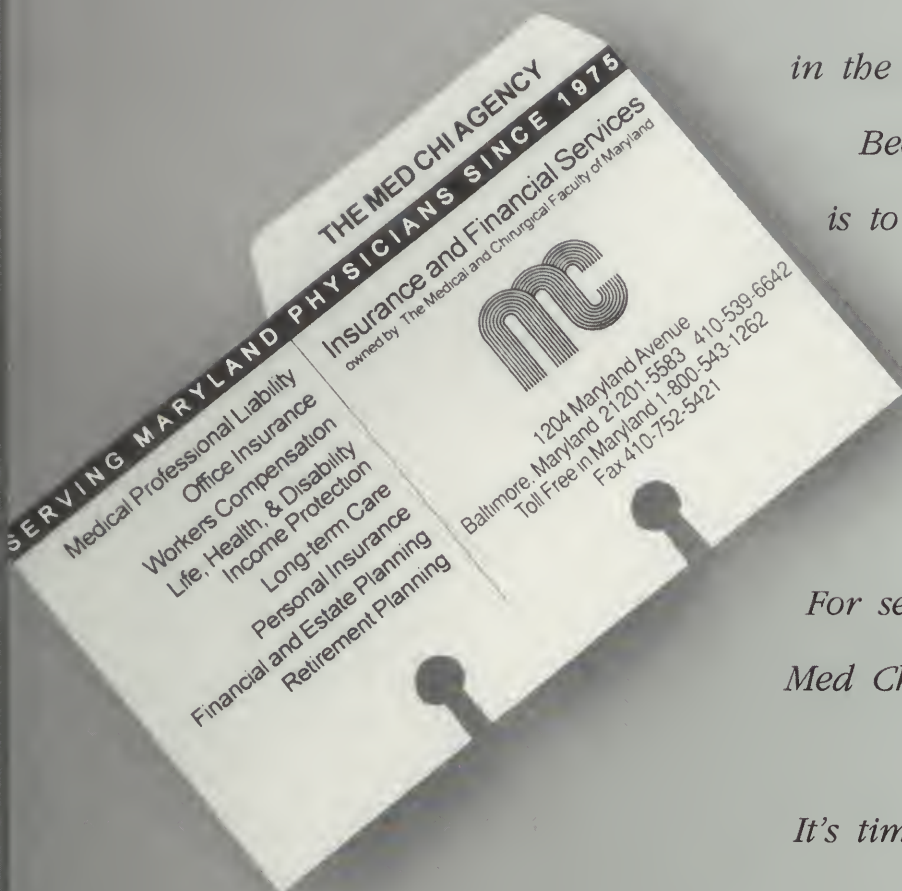
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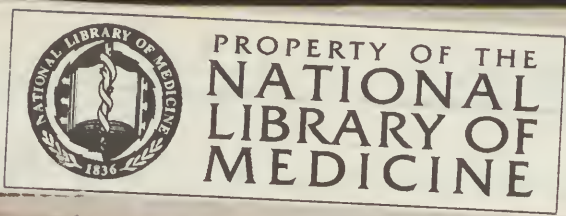
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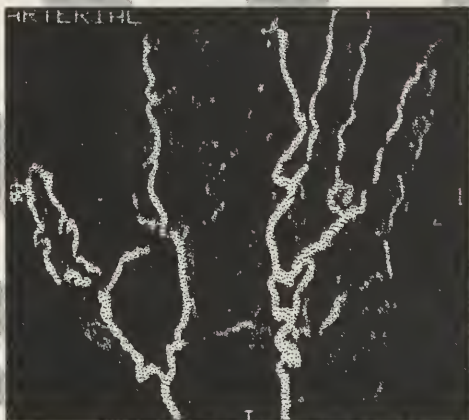
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Medicare National Coverage Decisions

MRIs — Effective March 22, 1994, Medicare covers magnetic resonance imaging to diagnose disc disease without regard to whether radiological imaging has been tried first to diagnose the problem.

Implantable Infusion Pumps — Medicare coverage guidelines have been revised to include coverage of implantable infusion pumps for use in the treatment of spasticity and chronic intractable pain of malignant or nonmalignant origin, if certain patient selection criteria are met.

Percutaneous Transluminal Angioplasty (PTA) — Effective March 17, 1994, Medicare coverage has been expanded to include PTA treatment of atherosclerotic obstructions of vessels in the upper extremities (which do not include head and neck vessels).

Collagen Implants — Effective July 1994, Medicare contractors must cover collagen implants used to treat patients with stress urinary incontinence due to intrinsic sphincter disorder who meet certain patient selection criteria. The injections are reimbursed as a prosthetic device, billed under Q0134, for which a separate payment will be made when furnished in a physician's office.

PBS Medicare Part B Operations

On January 1, 1995, Pennsylvania Blue Shield's Medicare Part B operations will begin operating under the name Xact Medicare Services. PBS chose the name Xact to represent the ideal level of service and quality PBS wants to provide. PBS believes that the name emphasizes accuracy, detail, and precision.

CLIA Billing Errors

HCFA will survey physicians in South Carolina and Utah to determine why so many physicians are billing for laboratory services not authorized by their CLIA status. The problem is nationwide but only two states are being surveyed to try to determine the cause of the discrepancy.

At the current time, it appears as if 22 percent of the clinical lab-test bills seem to be inappropriate. HCFA hopes that the survey results will clear up problems it is having in administering the CLIA program.

New OSHA Reporting Requirements

Effective April 1994, employers must report **work-related hospitalizations** of **three** or more employees and all **fatalities** to the nearest OSHA area office by telephone or in person within **eight hours** of their occurrence or having first learned of them. In Maryland, this reporting must be related to the Maryland Occupational Safety and Health office.

Aggregation of Claims

The Health Care Financing Administration implemented new regulations permitting the aggregation of denied Medicare Part A and Part B claims on appeal. The new regulations will enable beneficiaries, physicians, and other providers to more easily meet the minimum claim amount required to file an appeal.

One way that claims may be aggregated is by grouping together multiple payment denials to meet the minimum amount in controversy required to qualify for a hearing on appeal. This means that physicians will be able to combine two or more denied claims. A group of physicians could aggregate their claims if the group has one billing number, bills Medicare using that number, uses a uniform charge structure, and usually appeals as a single entity.

Another method of aggregation involves two or more beneficiaries or providers appealing by grouping their denials together provided that the claims involve: 1) the delivery of similar or related services to the same individual; or 2) common issues of law and fact arising from services furnished to two or more individuals.

Medicare - Flu Shots

It's flu vaccine time and all physicians are encouraged to offer the influenza virus vaccination to their Medicare patients. Medicare Part B reimburses for the flu vaccine and its administration at 100 percent of the Medicare allowed charge. Part B deductible and coinsurance do not apply to these charges. Medicare Part B covers the annual administration of the flu vaccine and the allowance is as follows: vaccine (CPT 90724) - \$3.38; administration (HCPCS Q0124) - \$2.67. There is no five percent payment reduction for nonparticipating providers.

Physicians may not charge for an office visit if the sole purpose of the patient's visit is to receive the flu vaccine. However, if other services are rendered which may be described by an evaluation and management code, physicians may bill for those services separately.

President's Western Regional Conference

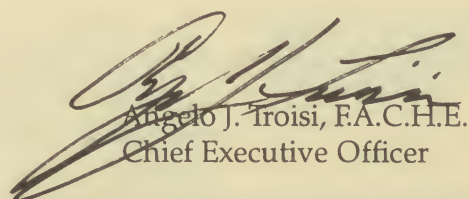
Thursday, October 27, 1994 at 5:30 p.m.
Sheraton Hotel, Hagerstown, Maryland

This conference is for members in Garrett, Allegany, Washington, Frederick, and Carroll counties. Conference topics will include a legislative preview, HCACC, and an update on small employer insurance reform. The meeting will also feature a one-hour continuing medical education presentation on "Substance Abuse Education for the Primary Care Physician."

For more information, or to register for this conference, contact Joan Mannion at 410-539-0872 or 1-800-492-1056. Registrations must be received no later than 12:00 noon on Monday, October 24.

AMA Television Commercial Storyboard

Immediately following this issue of the *Chief Executive Officer's Newsletter* is a copy of the storyboard for the first-ever AMA television commercial. The AMA purchased advertising time on Cable News Network and CNBS and the ad ran from September 13 - October 7, 1994. The AMA chose to use a television commercial to talk directly with patients and opinion leaders on behalf of physicians.


Angelo J. Troisi, F.A.C.H.E.
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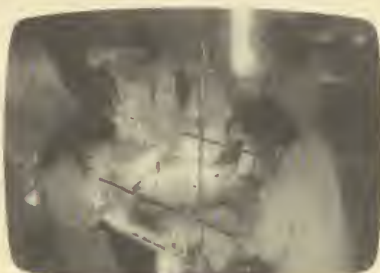
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But you have our pledge that we're going to do everything we can to make it happen.



PRESIDENT'S LETTER

Dear Colleague:

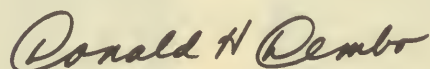
The month of October is dedicated to domestic violence awareness as originally established by the National Coalition Against Domestic Violence, and I am pleased to introduce this dedicated issue of the *Maryland Medical Journal (MMJ)* to you.

Domestic violence has recently received a plethora of publicity and the *MMJ* cover depicts some of the tragedies that have appeared in newspaper headlines. Our guest editorial this month is by Robert E. McAfee, M.D., President, American Medical Association, who has led the AMA's crusade against family violence. He has written a moving editorial concerning domestic violence. The other articles in this issue focus on topics of importance and interest to physicians, including domestic homicide and the duty to warn, treatment for perpetrators of domestic violence, survival responses of battered women, JCAHO standards for improving care to victims of abuse, legal protection for domestic violence victims, physicians as partners in change, legislative advances gained by the passage of the Domestic Violence Act of 1994, and legislative initiatives with the passage of the Domestic Violence Medical Response Act.

With the proliferation of violence in our homes, schools, and neighborhoods, I am proud of the efforts being made by the Maryland Physicians' Campaign Against Family Violence. During this last year, Med Chi joined forces with the Maryland Alliance Against Family Violence to initiate a vital campaign that recognizes family violence as a public health issue. This campaign places physicians in a leadership role in addressing this issue as part of a collaborative effort to confront family violence. For an update on the activities of the campaign and an acknowledgment of an award received by Med Chi's chief operating officer, read Ms. Ruth Seaby's article, "Developing the Maryland Physicians' Campaign Against Family Violence."

As physicians, we have a responsibility to provide health care that meets the needs of our patients. Our patients are hurting and suffering because of abuse. Please join with Med Chi to alleviate and eradicate this suffering by learning about the problems associated with abuse and being part of the solution through the Maryland Physicians' Campaign Against Family Violence.

Sincerely,



Donald H. Dembo, M.D.
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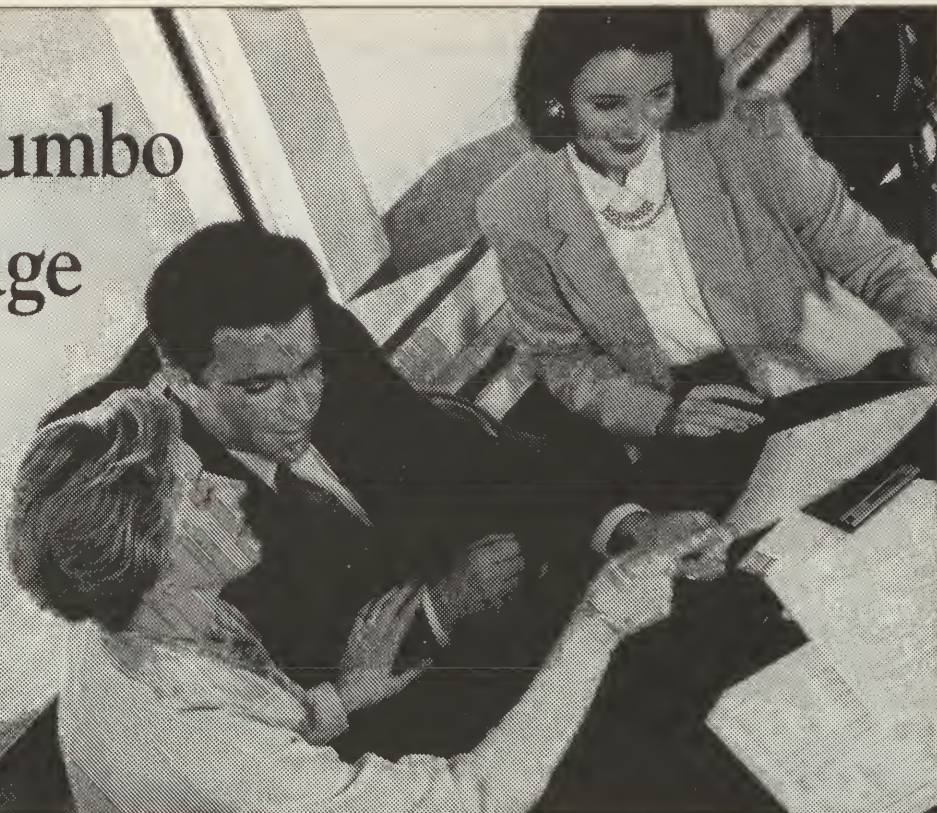
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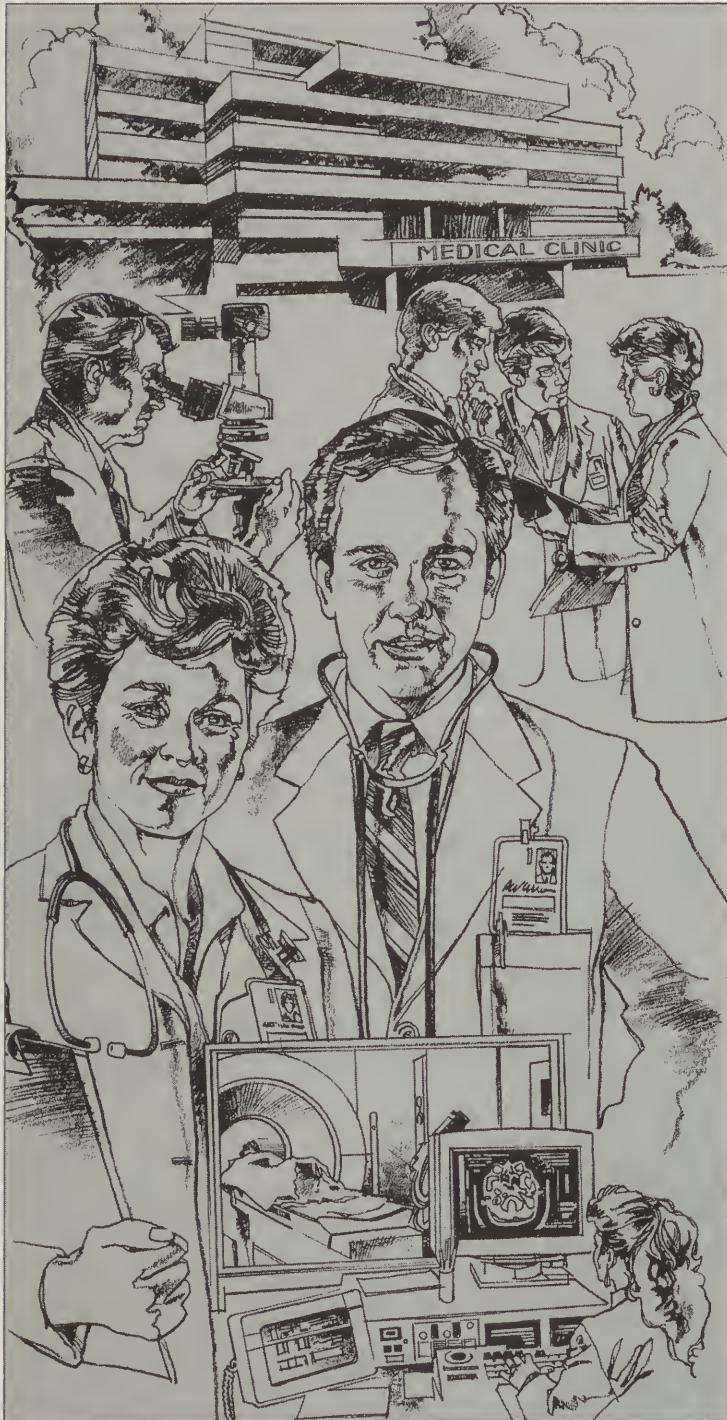
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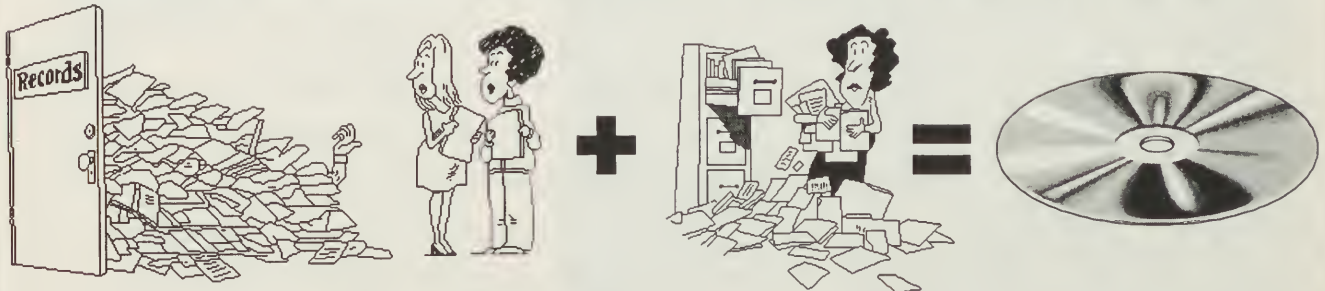
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Lines of defense: Domestic Violence Awareness Month

Robert E. McAfee, M.D.

Dr. McAfee, a surgeon practicing in Portland, Maine, is president of the American Medical Association.

America is a nation at war, and the struggle is as close as our own living rooms. Every day we read about gangs battling on our urban streets, the pernicious hold drugs still have on many of our youth, and the continuing fight against AIDS. We are less likely, however, to read about the war played out within the American family, where the front lines lie hidden behind the front doors of our communities. This is the battlefield of domestic violence, where the casualties are enormous and the heroes far too few.

It has been said that heroes are those who do what they can. With so much that physicians can do in this crisis, the hour for quiet heroism is upon us. October is Domestic Violence Awareness Month, a chance for us to take stock of our efforts. As we do, however, we must remember that for the victims, domestic violence is not merely a month-long affair—it is a daily, a weekly, and all too often, a lifelong struggle.

By the time you have finished reading this sentence, another woman in the United States will have been beaten, battered, and bruised by someone she knows. Every 12 seconds, 24 hours a day, 365 days a year, a woman is punched, kicked, slapped—or worse. Every decade, domestic violence kills as many women as the total number of Americans who died in the Vietnam war.

The damage does not stop, however, with the lives and bodies of women. Domestic violence targets all of the most vulnerable among us, including small children and the frail elderly. Two thousand American children are beaten and starved to death every year, and millions more suffer the horrific effects of ongoing abuse and neglect. It is hard to measure how many millions more victims are ignored or overlooked, *because physicians fail to properly identify as many as 95% of the victims of domestic violence.*

The security of a physician's office may be the only sanctuary the patient can find in a personal hell of violence and neglect. We have a responsibility—not only as physicians, but as citizens and community members—to create the necessary impact to stem this growing American epidemic.

We must begin with our own awareness of violence in the family. I will never forget the day I met a cardiologist who started a hospital-based treatment center in Kenosha, Wisconsin, for abused women.

"I understand you treat battered women," I said as we were introduced.

He replied, "And so do you."

My education began at that instant.

What he meant was that when physicians examine patients with cuts and bruises and broken arms, we may actually be treating victims of abuse.

With a problem as prevalent as domestic violence, the American Medical Association's guidelines for diagnosis and treatment recommend *routine* screening in the primary care setting. We must be on the lookout, because AMA research shows that 80% of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence. Patients trust their physicians. What physicians need are the right tools, and the AMA has them at hand.

In 1990, we formed the National Coalition of Physicians Against Family Violence, now more than 6,000 members strong. The coalition keeps physicians informed about resources, model programs, speakers, and public education materials. Participants receive the AMA Diagnostic and Treatment Guidelines on child and elder abuse and domestic violence, as well as patient materials bearing the message, "When you break the silence, you begin the cure."

It will take more than openness or good medicine to make the cure complete, however. Physicians should become familiar with the range of resources in the community: shelters, legal advocacy, counseling, support groups, crisis hotlines, and your state medical society Alliance. Look also to the extraordinary grass-roots efforts of our own federation, where physicians like you have already taken this issue to heart. To turn the tide in a war of this magnitude is going to take every available recruit, side by side, attacking on as many fronts as possible. It is going to take lawyers, judges, and the police; concerned citizens and local communities; all of us engaged in health care; and the victims themselves—all working together.

To do *your* share to recognize and treat victims of domestic violence, just keep your professional **RADAR** turned on:

- ❑ Remember to screen your patients about violence.
- ❑ Ask questions such as, "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?"
- ❑ Document your findings. Information in the patient's chart about "suspected domestic violence" can serve a valuable function in court should the patient seek legal action. A physician's documentation validates the victim's allegations.

- ❑ Assess your patient's safety. Is it safe to go home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.
- ❑ Review options with your patient. Know about referral options.

Remember, the public entrusts us with their care, and many of us have already chosen to be the heroes that their physical and emotional pain demand. But to gain a beachhead against this national epidemic, there is not a person—or a moment—to spare. As physicians, as citizens, as parents, as sons and daughters, we must work together to break the silence and end the violence, beginning now with Domestic Violence Awareness Month, and throughout this and every year. ■

Understanding survival responses of battered women

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ABSTRACT: *Battered women often endure years of physical, psychological, and/or sexual abuse at the hands of an intimate partner. To intervene effectively, health professionals need to understand both the external factors and the complex conditioning process that keep many women trapped in abusive relationships. Many of the physical and psychological symptoms shown by battered women can be understood as complex survival strategies and responses to the abuse.*

In 1991, the American Medical Association launched the national Physician's Campaign Against Family Violence. The goal of the campaign is to encourage physicians to recognize family violence as a health problem requiring medical intervention. In 1993, the Medical and Chirurgical Faculty of Maryland and the Maryland Alliance Against Family Violence launched a similar statewide campaign to help physicians and other health professionals include routine assessment, intervention, and referral for victims of family violence. The focus of the first phase of the Maryland campaign has been on intervention with victims of partner abuse, who are primarily battered women.

This article highlights the dynamics that affect how battered women respond to chronic abuse. Understanding the complex survival responses and strategies used by battered women can help reduce the frustration of health professionals in working with this population. Without a thorough understanding of the seemingly paradoxical choices of many victims, physicians may become frustrated and stop using appropriate intervention skills that are being encouraged in both the national and state campaigns.

The most frequently asked question concerning battered women is, Why do they stay? There is an abundance of evidence that a woman stays with an

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abusive partner because she is unable to gain access to the safe housing, jobs, child care, finances, and legal protection needed to be safe and self sufficient. Unlike victims of other crimes, battered women are legally bound, economically dependent, and emotionally involved with their assailant. It is difficult to escape when there is no safe place to go and there are insufficient financial resources to live independently. Many judges are reluctant to sentence an abuser to jail or deny a father the right to visit his children. Thus, a woman who does escape often finds herself in continuing contact with the abuser during court-ordered visitation arrangements or because the abuser has simply tracked her to her new location.

Even when physicians acknowledge these compelling external factors, the question continues to linger. The belief that a battered woman could leave if she really tried or stays because she is sick or dysfunctional may affect the quality and type of care physicians provide. In addition, without understanding the dynamics of domestic violence, physicians may observe physical and psychological symptoms in this population that may be mistaken for the cause rather than the result of the abuse.

Battered woman syndrome

The battered woman syndrome was first described by Walker,¹ a psychologist who conducted extensive research with battered women and observed a number of consistent patterns in their responses to the abuse. According to Walker, battered woman syndrome is a collection of psychological symptoms that are commonly observed in victims of repeated physical, sexual, and/or psychological abuse by an intimate partner.

Blackmun,² a social psychologist, identified four characteristics of women who have been repeatedly battered. First, psychological changes cause them to believe they are unable to control what happens to them, particularly to stop the violence. Second, they have a high tolerance for cognitive inconsistency. Third, they have a sense that alternatives are not available to them. Fourth, they develop a continuum along which they attempt to rate the tolerability or survivability of episodes of their partner's violence. The last characteristic has been used to help understand why certain battered women may act in self defense after a long period of seeming passivity or tolerance of the abuse.

The battered woman syndrome has been used primarily in legal proceedings to help juries or triers of fact to understand the state of mind of the battered woman who attempts or commits homicide against her partner. A number of theorists and practitioners, however, have objected to use of the syndrome to explain women's actions, saying such use diverts attention from the right of self defense and pathologizes the victim.³

Battered woman syndrome is listed in the ninth edition of the *International Classification of Diseases*.⁴ In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, a description of the effects of abuse is included in the posttraumatic stress disorder category. In addition, a new classification that does not presume psychopathology on the part of the victim was created for use when the focus of clinical attention is severe physical or sexual abuse of one individual by another.⁵

Battered woman syndrome is a survival response to the behaviors displayed by an abusive partner. It describes a terrified woman's normal response to an abnormal and life-threatening situation. It does not assume the battered woman was at fault or had any predisposing pathology that made her more vulnerable. Nor does it assume the victim is sick as a result of being battered. It is most closely associated with trauma theory in its description of predictable reactions seen in otherwise normal people who are victims of a catastrophic, life-threatening event that is beyond their control, such as being held hostage or being a prisoner of war.

Regardless of race, class, or other demographic variables, abusers use similar tactics.⁶ Physical abuse may include pushing, shoving, slapping, hitting, punching, kicking, hitting with an object, throwing bodily, choking, burning, using a deadly weapon, imprisoning for extended periods of time, and/or forcing sexual activity that is degrading and causes injuries. Psychological abuse includes social isolation of the victim; excessive jealousy and surveillance; threats to harm the victim, children, or loved ones; and acts that intimidate the victim into compliance. Emotional abuse includes verbal harassment and denigration, alternating cycles of brutality and showing mercy, and blaming the victim for the abuse. These tactics are common behaviors in battered spouse/battering spouse, hostage/captor, abused child/abusive parent, and prisoner/guard relationships.⁷

Similarities in the pattern of abuse in such relationships also has been observed. The pattern begins with attempts by the abuser to isolate the victim from contact with the outside community. The abuser uses violence, threats, and intimidation to establish a position of dominance and evoke fear and compliance in the victim. The abuser uses small reminders of the abusive episode to remind the victim of what the abuser is capable of doing if she does not comply with his expectations. Following an abusive episode, the abuser may suddenly demonstrate some kindness or mercy towards the victim. In cases of domestic violence, the abuser may beg for forgiveness and promise never to harm the victim again.

Despite the abuser's promise to reform, however, once a pattern of abuse occurs, it is likely to become more frequent and

severe over time. An abuser may begin with slapping, but a year later may be threatening to kill.⁸

Abusers typically minimize and deny the pain and trauma they cause their victims. They believe they are entitled to maintain their positions of dominance and usually blame their actions on the victim. They may even believe their actions help teach the victim a necessary lesson. Some abusive partners genuinely regret their violent acts, but few seek help without criminal prosecution and court-ordered treatment. Many abusers are also addicted to drugs and/or alcohol. Although addiction does not cause the abuse, it may result in more severe violence.

Paradoxical behaviors of victims

One would expect victims to respond to acts of violence and captivity with outrage and persistence in finding a means of escape at all costs. Research involving a variety of victim groups, however, documents seemingly paradoxical responses, including denial of the danger, passivity, shame, self-blame, unrealistic hope that the situation will change, and emotional bonding with the perpetrator or captor (the Stockholm syndrome).⁷ Ordinary people held hostage by terrorists have bonded with those who had threatened them when four conditions were present: threat of death or serious injury; inability to escape the captor; isolation from the outside world so that the only available perspective is that of the captor; and perception of the captor as being alternately threatening and merciful. Individuals subjected to these conditions begin to identify with the aggressor, develop sympathy for him, resist efforts to escape, and develop antipathy towards authorities working for their release. These responses have been observed within days of captivity among otherwise highly functioning adults.⁹

Stages of victimization

Individuals go through predictable stages after experiencing a life-threatening event.¹⁰ In the first stage, victims experience shock, disbelief, denial, fear, and confusion. This reaction interferes with their ability to define the true extent of the threat or to make a complete assessment of available options. Stage two includes a state of heightened suggestibility and dependency during which passivity and submission to the demands of the attacker are common survival responses. In the third stage, victims develop unrealistic hope that the event will soon be over and the damage will not be too bad. If the level of danger is severe and continuing, victims then pass into the fourth stage, which is characterized by withdrawal and failure to use escape strategies that may in fact be available. In essence, they learn they are helpless and surrender to a situation perceived as being hopeless.

Normal recovery from even a single incident of violence frequently takes months. Even when the victim is safe from the perpetrator, symptoms of posttraumatic stress syndrome¹¹ (intrusive memories of the event, nightmares, feelings of fear and helplessness, sleep disorders, chronic fatigue, tension) may persist and interfere with the person's ability to function.

Unique aspects of battered women's victimization

Despite similarities between abusive partners and others who seek to maintain total control and dominance over another person, several factors make a battered woman's relationship with her assailant more binding than what is observed in stranger-to-stranger situations and her escape more difficult.¹²

Expectation of an equal intimate relationship. One might expect to be victimized by a stranger, but not by an intimate partner. Thus, the battered woman is more prone to shock and disbelief as an initial reaction. There also may be prolonged periods when the abuser is nonviolent that reinforce her belief that she is not in danger and justified in remaining with him.

Acceptance of responsibility for relationship problems. The abuser blames his actions on the behavior of the woman, who has been socialized to accept responsibility for maintaining peace in the relationship. Thus, in the initial stages of victimization, she may focus on changing her behavior rather than escaping. She may go to elaborate lengths to "keep the peace" because she believes it will prevent the recurrence of abuse and because she wants to keep the family or relationship intact. She cannot accept the fact that, ultimately, she is powerless to stop his violence. She may become increasingly submissive in an attempt to exert some control over her situation, falsely believing that if she complies with all demands, the abuser will cease to harm her. Her submissiveness initially may function as a survival tactic, but as the violence escalates, her passivity interferes with her ability to escape.

Legal, economic, and emotional ties. Unlike victims of crime by a stranger, the battered woman is legally, economically, and socially enmeshed with her abuser. Battered women typically endure repeated abuse and use a variety of informal strategies to avoid attacks before they request help from the community. When they do ask for help, however, they may find that the community is often unable to protect them or offer the means for them to live independently from the abuser. The community is simply not equipped to provide the comprehensive, long-term protection victims need to be safe.

Friends and family members frequently encourage women to stay for the sake of the children and the marriage. The criminal justice system historically has failed to treat domestic assault as a crime or to allocate the necessary resources for vigorous prosecution, detention, and community supervision.

Available legal remedies may not offer adequate protection or are simply not enforced.

The woman who attempts to relocate often fails due to a lack of emergency shelter and low-income housing for herself and her children. The abuser knows or can usually find the location of her home, friends, and job. He can continue to harass, threaten, and abuse her regardless of what legal sanction exists. It is common for abusers to hunt down their victims, even in other states. The victim is then forced to go home because the abuser threatens to harm her, her children, and her loved ones if she fails to comply.

Abusers are intent on controlling their victims and many threaten to kill the woman if she leaves; in fact, most homicides of the woman occur after she has left the relationship. Women may choose to stay because they know the violence will only escalate if they leave. Thus, the ties meant to bind a family become the means for an abuser to hold the victim in captivity.

Endurance of years of abuse. Ordinary people held captive for a few days begin to show debilitating responses. Women who have been raped may suffer from posttraumatic stress syndrome for months. Yet battered women often endure years of the physical trauma of repeated violent assaults and the psychological trauma of being systematically degraded, humiliated, and blocked from escaping their abuser. Battered women frequently minimize, deny, and repress the abuse as a survival strategy. Some develop the fight symptoms associated with high arousal (anxiety, fear, sleep disturbance, hypersensitivity to cues of future danger). Flight symptoms associated with the avoidance criteria may appear in the form of a pervasive feeling of helplessness, depression, isolation, emotional numbing, and a sense of foreshortened future. Drug and/or alcohol addiction often becomes a way of obtaining immediate short-term relief from psychological and physical pain. A significant percentage of female suicide attempts also are related to domestic violence.¹³

The battered woman becomes caught in a vicious cycle. First, she loses her belief in her own ability to stop the abuser. Then, she sees evidence that the community cannot stop him (battered women sometimes report viewing their abuser as being omnipotent and capable of executing every threat). She is abused whether she stays or leaves. As the violence and degradation become more frequent and severe, her self-esteem erodes completely. She is deeply ashamed to admit to herself or others what she is enduring. Her silence is then mistaken for complicity.

A hostage-taking episode usually results in a great deal of public attention and a groundswell of support for the victims. Battered women are viewed less sympathetically. Although society supports those who defend themselves against perpetra-

tors of stranger-to-stranger crimes, it has historically blamed battered women for staying in the abusive situation or indicated they are somehow deserving of the abuse. Spouse abusers are rarely punished, even when there have been multiple contacts with the legal system.

When battered women kill

Research indicates that in extreme environments, people may alter their behavior dramatically to survive. Thus, the battered woman may adapt to increasingly dangerous behavior because she is forced to coexist with her abuser. The threshold of acceptable behavior is stretched so that constant tension and danger become the status quo. The battered woman progresses from being shocked by the violence to being thankful that she survived another attack. As the years pass, she adjusts to levels of abuse that would have been unendurable at an earlier stage.¹⁴

Several studies have examined the life histories of battered women who killed their abusers.^{8,14,15} Browne¹⁴ compared a group of battered women who killed their abuser with a group who did not. She found that battered women who killed were significantly more likely to have been battered once a week, threatened with death, threatened with weapons, forced to watch children be physically and sexually abused, forced into violent and unwanted sexual activity, threatened with retaliation if they left, and socially isolated. In addition, battered women who killed were more likely to report that the abuser was alcoholic.

Research also has shown that many battered women who killed their abusers experienced some change in the pattern of abuse that led them to believe they or their children were about to be killed. Although the woman may have endured severe brutality, the abuser committed or threatened some act that went beyond the range she believed she could survive. In some cases, the battered woman killed her abuser when he was not attacking her because she did not believe in her ability to defend herself in the middle of a violent episode. Battered women who killed did not walk out the door or call the police because their cumulative experience with the abuser and the community had convinced them that such actions would not ensure their safety.

Several years ago, through extensive interviews with more than 30 inmates at the Maryland Correctional Institution for Women, the Public Justice Center Domestic Violence Task Force determined that a number of women serving prison sentences for the attempted or actual homicide of their partners had extensive histories of being physically abused by that partner. Nevertheless, evidence of the abuse and its effects on the state of mind of these women had been excluded during their criminal trials. In 1991, however, the Maryland General Assembly passed legislation that modified evidentiary rules

regarding prior domestic violence in cases of felony assault or murder charges against an intimate partner. The statute now allows introduction of evidence of battered spouse syndrome to explain a defendant's motive or state of mind. It also allows expert testimony on the psychological condition of a victim of physical and psychological abuse by a mate.

Both the national and statewide family violence campaigns stress the important role of physicians in the identification and documentation of partner abuse. Identification is essential to ensure effective intervention. Documentation may serve an important role in legal proceedings that could determine the long-term safety of the victim.

Myriad external factors and complex conditioning processes keep many women trapped in abusive relationships. Understanding these forces in a patient's life provides an essential context for physicians to guide decisions about medical and mental health interventions.

References

1. Walker L. *The Battered Woman Syndrome*. New York: Springer; 1984.
2. Blackmun J. Potential uses for expert testimony. *Women's Rights Law Report*. 1986;9:227-238.
3. Schneider EM. Describing and changing: women's self-defense work and the problem of expert testimony on battering. *Women's Rights Law Report*. 1986;9:195-222.
4. *International Classification of Diseases*. 9th rev. Los Angeles: Practice Management Information Corp; 1993.
5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994.
6. Pence E, Paymar M. *Education Groups for Men Who Batter: The Duluth Model*. New York: Springer; 1992.
7. Dutton D, Painter SL. Traumatic bonding: the development of emotional attachments in battered women and other relationships of intermittent abuse. *Victimology* 1981;6:139-155.
8. Walker LE. *Terrifying Love: Why Battered Women Kill and How Society Responds*. New York: Harper Collins; 1989.
9. Ochberg F. The victim of terrorism: psychiatric considerations. *Terrorism* 1978;1:147-168.
10. Symonds M. Victims' responses to terror: understanding and treatment. In Ochberg FM, Soskin DA, ed. *Victims of Terrorism*. Boulder, CO: Westview; 1982.
11. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, DC: American Psychiatric Association; 1987.
12. Graham DL. Survivors of terror: battered women, hostages and the Stockholm syndrome. In: Yllo K, Bograd M, ed. *Feminist Perspectives on Wife Abuse*. Newbury Park, CA: Sage; 1988.
13. Stark E, Flitcraft A, Zuckerman D, Grey A, Robison J, Frazier W. *Wife Abuse in the Medical Setting*. Rockville, MD: National Clearinghouse on Domestic Violence; 1981.
14. Browne A. *When Battered Women Kill*. New York: Free Press; 1987.
15. Ewing, CP. *Battered Women Who Kill: Psychological Self-Defense as Legal Justification*. New York: Free Press; 1987. ■

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Treating perpetrators of adult domestic violence

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ABSTRACT: *This article reviews the emerging research on domestic violence offenders. A number of psychological and behavioral factors are correlated with battery, including pervasive psychological abuse, alcohol problems, violence in the family of origin, emotional insecurity, and features of antisocial and borderline personality disorders. Youthfulness, low socioeconomic status, and low educational attainment are also correlated with marital violence, yet it is common in all demographic groups. Research on the effectiveness of counseling for domestic violence perpetrators is quite limited. Some studies have shown that counseling adds significantly to the effects of arrest in reducing domestic violence. High recidivism rates are common, however, with over 25% of offenders engaging in physical aggression within one to two years after treatment. Counseling for domestic violence perpetrators should be part of a coordinated community response that includes criminal justice interventions, preventive education, and comprehensive victim services.)*

Theoretical perspectives

While a wide variety of theories have been developed to explain spousal violence, feminist, relationship system, and individual psychopathology theories predominate in current research and practice. Each has empirical support, but none is comprehensive in scope.

Feminist theories. By feminist accounts, men batter to dominate women in the domestic sphere.^{1,2} The feminist perspective derives considerable support from historical and cross-cultural research. For example, wife beating was supported by British common law through the "rule of thumb," which allowed a husband to beat his wife provided that he used a switch no

wider than his thumb.¹ The application of this tradition in America is exemplified by an 1867 North Carolina court ruling that acquitted a man for hitting his wife with a switch the size of his finger. The decision was upheld on appeal, with the argument that the court should “not interfere with family government in trifling cases.”² In cross-cultural studies, wife beating has been found to be more common when men dominate the domestic sphere through control of family wealth, exclusive male ability to acquire wealth, and exclusive male ability to own a home. Wife beating is less common in cultures with female work groups and more common in cultures that keep women isolated from one another.³ In the contemporary United States, gender inequalities also contribute to this problem. For example, economic dependency is a major factor in women’s decisions to return to an abusive spouse after time in a shelter.⁴

Direct application of feminist theory in understanding the psychology of individual batterers has met with more limited success. For example, the hypothesis that male spouse batterers maintain more sexist attitudes than the average U.S. male has received very little empirical support.⁵ Rather than being preoccupied with fantasies of power and control, most batterers are preoccupied with intimacy and abandonment, concerns not usually associated with the macho male role.^{6,7} In addition, the high rates of physical abuse in gay male and lesbian relationships have led some scholars to reappraise gender-based explanations.⁸

Relationship system theories. By relationship system accounts, both members of a couple escalate their hostile and coercive interchanges to the point of physical violence.⁹ Compared to individuals in nonviolent relationships, partners in physically abusive relationships express more frequent and more reciprocal hostility during problem discussions.¹⁰ Early in marriage, the first instances of physical aggression are predictable from prior levels of verbal aggression by both parties, suggesting a coercive interpersonal system.¹¹

Relationship system theories may account for initial escalation to physical aggression in which one or both partners throw things, slap, push, or grab one another during an intense conflict. More severe assaults and their effects, however, are more likely to be unilateral. When injuries or police involvement are assessed, the abuse is perpetrated by men against women in 85% to 95% of heterosexual cases.¹² By clinical accounts, severe battery in gay and lesbian relationships also conforms to a perpetrator/victim role dynamic.

Individual psychopathology theories. Another set of theories suggests that batterers have individual histories, personality characteristics, or forms of psychopathology that predispose them to assault intimate partners. Supportive research has found evidence for high rates of experienced and witnessed

abuse in childhood, low self-esteem, high interpersonal dependency, high levels of depressive symptoms, high levels of hostility and anger, high rates of substance abuse, borderline personality characteristics, antisocial personality characteristics, and other personality disorders among clinical samples of men who batter. Many of these findings have been replicated across samples and sites.

Despite a variety of important clinical correlates of battering (discussed below), some of these theories lack a coherent explanation for the link between psychological disorders and abusive behavior. Many male spouse batterers do not meet current diagnostic criteria for any major mental disorder, and many individuals with these psychological characteristics manage to avoid abusing their partners.

Correlated clinical features

Demographic factors. One consistent demographic correlate of relationship abuse is age. In national surveys, the prevalence rate of marital violence reported by women between the ages of 18 and 29 was about twice as high as the rate for women in their 30s and about three times as high as the rate for women in their 40s.¹³ Although marital violence occurs in all social strata, it is somewhat more prevalent among less educated individuals and those with lower socioeconomic status. The prevalence is higher among African Americans and Hispanic Americans than among non-Hispanic white Americans, but the differences can be accounted for by differences in income, occupational status, and urbanicity.^{14,15}

Other abusive behavior. Physical abuse is almost always part of a larger pattern of coercive relationship behaviors that instill fear, increase dependency, and threaten the partner’s self-esteem.¹⁶ Batterers commonly track, monitor, and control the partner’s activities and social contacts; denigrate, ridicule, or otherwise degrade the partner; destroy the partner’s personal belongings or property; unilaterally control family finances; sexually coerce or rape the partner; and threaten to harm the partner, the children, friends, relatives, pets, or others. Although many batterers stop their physical violence in response to intervention, the majority continue to threaten and coerce their partners after treatment.¹⁷

Alcohol abuse. Surveys document a significant correlation between alcohol consumption levels and marital violence in the U.S. population.¹⁸ Serious alcohol problems affect up to 50% of clinical batterer samples. Marital violence is also common among married male alcoholics, over half of whom are physically aggressive toward their spouses in the year before alcoholism treatment.¹⁹ Abusive spouses are acutely intoxicated in about 40% of domestic assaults.²⁰ Among alcoholics, marital violence is associated with onset of pro-

blem drinking at an early age, binge drinking, other antisocial behavior, and more male-limited family histories of alcoholism.¹⁹

Treatment for the alcoholic spouse batterer presents many challenges. These individuals have higher recidivism rates and higher treatment dropout rates than nonalcoholic batterers.^{21,22} A recent study found that for most male alcoholics, marital violence abates upon remission of active drinking.²³

Family of origin violence. In clinical samples, about 50% of batterers report having been physically abused in their childhoods, and about 50% report having observed physical violence between their parents. Approximately 75% were exposed to one or the other of these forms of violence. These figures must be interpreted cautiously, however, because many individuals who are exposed to violence in the family of origin manage to break the cycle of abuse.

Batterers who were physically abused in childhood tend to perpetrate more frequent physical and psychological abuse toward their partners and display more evidence of psychological distress than do batterers without such histories.²⁴ Despite widespread interest in treating adult sequelae of childhood victimization, there are as yet no published studies examining such therapies as a treatment for partner assaultive individuals.

Emotional insecurity. Batterers evidence low global self-esteem and high levels of dependency within their relationships.⁶ They perceive a great deal of personal threat in marital disagreements.²⁵ Conflicts over the partner's independence and autonomy are particularly difficult for these individuals, reflecting a hypersensitivity to rejection or abandonment.^{7,26} These insecurities may motivate controlling and demeaning behaviors, which further alienate relationship partners in a vicious cycle.

Personality disorders and emotional distress. As a group, batterers report high levels of emotional distress, including anger, hostility, and depressive affect.²⁷ After accounting statistically for general emotional distress, the most prominent personality problems among batterers are antisocial, aggressive, and impulsive features.²⁴ Generalized impulse-control problems, extreme mood fluctuations, and unstable attachments may reflect antisocial or borderline personality disorders. Structured personality assessments have not identified a specific batterer "profile," leading some researchers to conclude that there are distinct subgroups.

Neurophysiological factors. Several biological factors have been implicated in human aggression. Only acute intoxication and head injury have been directly studied in domestic violence offenders. In one small-scale study, 61% of batterers had histories of severe head injury, compared to a population base rate of about 5% to 6%, suggesting a possible role for neurophysiological disinhibition.²⁸

An association between serotonin metabolism and impulsive aggression has been documented consistently in studies of violent male offenders and psychiatric patients by measuring concentrations of 5-hydroxyindoleacetic acid in cerebrospinal fluid.^{29,30} Irritability linked to hypoglycemia and other hormonal or nutritional factors may enhance aggressive tendencies. Although large-scale studies have found very low rates of violence among epileptic patients in general, complex partial seizures in the temporal lobe and more subtle limbic seizures may be implicated in some cases of episodic dyscontrol syndrome. Aggression may also be associated with physiological and emotional changes that occur during manic or hypomanic episodes and with other biological conditions.³¹ To date, however, these factors have not been examined specifically in association with domestic violence.

Batterer subgroups

Clinical researchers have begun to identify subgroups of batterers with different psychosocial profiles. The proposed subgroups may reflect arbitrary cutoffs along a continuum of clinical severity or distinct categories with different underlying causes. Most studies have found that "bad things go together," i.e., the severity and frequency of battering are correlated with alcohol problems, family of origin violence, and generalized aggressiveness. The foremost subtyping scheme has identified three groups.³²

Antisocial or generally violent batterers. These individuals have a relatively extensive history of violence directed toward strangers outside the family. Their abusive behavior tends to be more severe and sadistic than that of other batterer subgroups, and they are more likely to abuse children. Most have substance abuse problems, many have extensive criminal records, and many were severely abused in childhood. Clinical experience suggests that these individuals may be very difficult to treat successfully.

Family-only batterers. These individuals, who account for about 50% of the clinical batterer population, have limited histories of violence or criminal activity outside the family. They fall within the normal range on most assessments of psychopathology, but are emotionally dependent and insecure in their attachments. Their abuse tends to be less severe than that of the other two subgroups. Clinical evidence suggests that this group may successfully control physical violence in response to legal and psychological interventions. Some may also benefit from couples' therapy if it can be conducted in a safe, collaborative, and noncoercive fashion.

Emotionally volatile or borderline batterers. These individuals have less severe impulse-control problems than antisocial batterers, but are more psychologically distressed and emotionally unstable than family-only batterers. Their vio-

lence falls in the range between the other two subgroups and is often linked to intense mood swings in a "Dr. Jekyll, Mr. Hyde" pattern. Most have a limited history of violence toward strangers. These individuals are intensely preoccupied with abandonment and jealousy. Many have drug and alcohol problems, and some have a depressive disorder or borderline personality disorder.

Types of treatment available

Until the late 1970s, very few specific programs treated domestic violence offenders. In the 1980s, hundreds of batterer counseling programs developed around the country. Most clients served by the original programs were self-referred. Batterer treatment is increasingly being offered to court-mandated clients as a condition of probation.

Treatment programs and clinical writings reflect a variety of theoretical perspectives. The two most common treatment approaches are cognitive behavior therapy and feminist therapy, which are usually conducted in men-only groups under the assumption that feedback from other batterers, a supportive group atmosphere, and public discussion of abusive behavior are important components of treatment.

Cognitive behavior therapy. Behavioral approaches assume that domestic violence is learned behavior, often linked to inadequate emotion regulation, interpersonal problem-solving deficits, and limited communication skills.³³ Treatment emphasizes anger management. Clients monitor somatic, cognitive, and situational cues for anger and violence. They practice strategies to regulate arousal such as deep muscle relaxation and rational restructuring of angry thoughts. Some programs emphasize assertive communication and relationship problem-solving skills.

Feminist therapy. Feminist approaches focus on the instrumental qualities of abuse in establishing power and control over female partners.³⁴ Batterers are educated about the link between male power in the society at large and the use of violence to defend male privilege in the home. Batterers are encouraged to strive for an alternative relationship style based on equality and partnership. Treatment helps men to identify their use of control tactics, along with the intentions and beliefs used to justify these behaviors. Feminist programs explicitly disavow a causal role for factors such as anger, relationship conflict, or substance use, interpreting them as excuses for willfully directed attempts to control an intimate partner.

Couples' treatment. Some clinicians advocate couples' treatment for reducing conflict associated with domestic violence.⁹ Couples' treatment is designed to limit hostile conflict sequences and enhance communication and problem-solving skills, but the approach is very controversial.

Most feminists argue that couples' treatment places responsibility on women for their victimization, intimidates victims, inhibits them from expressing themselves, and may stir up difficult issues that lead to further violence.³⁵ To date, there is no empirical support for these criticisms, but the generally accepted practice is to counsel batterers and victims separately.

Other treatment models have been proposed, but are less widely used. These include unstructured supportive group therapy, exploration of childhood abuse in individual or group therapy, and eclectic treatments.

Treatment effects

To date, there have been many clinical descriptions of treatment for batterers, with heated debates about the proper treatment approach. Unfortunately, very little controlled research is available to guide treatment decisions. Any review of this topic must also consider the high dropout rates. In many court-mandated programs, approximately 50% of individuals never call for services or disappear after the intake, highlighting the need for careful cooperation among treatment providers, probation agents, prosecutors, and judges.

Recidivism rates. Recidivism can be defined as any physical violence toward the spouse detected through criminal justice records, self reports, partner reports, or some combination of sources. In a review of 25 studies, post-treatment recidivism rates ranged from 0% to 100%, with a weighted average of 27%.³⁶ Average recidivism varied by reporting source; the lowest estimate (7%) was derived from official statistics and the highest (36%), from partner reports. Men who failed to comply with court orders had slightly higher recidivism rates than program completers. Across several studies, men who were court-ordered to counseling did not have appreciably different recidivism rates or program completion rates than men who sought treatment voluntarily.³⁶

Predictors of recidivism. Factors that have been associated with increased recidivism risk include active substance abuse problems, prior domestic violence arrests, violence in the family of origin, narcissistic and aggressive personality characteristics, and an unwillingness to call on counseling staff or other supports during a crisis.^{21,22} Batterers who live alone during counseling are at decreased risk for recidivism.²¹ Higher levels of depression at intake, perhaps indicating remorse, also predict lower recidivism risk.³⁷

Effectiveness of counseling. Only three studies to date have used adequate control groups to examine the effectiveness of group counseling for batterers. Of these, two found that treatment significantly reduced recidivism^{37,38} and one found that it did not.³⁹

One study evaluated a 16-week cognitive-behavioral intervention. The comparison group had been denied treatment

for a variety of reasons, mostly practical (e.g., distance to the treatment facility). The groups were matched on background demographic factors. During a one- to three-year follow-up period, 40% of the control group and only 4% of the treated group generated new police reports of domestic violence.³⁸

The second study evaluated a 10-week (15-hour) program that included elements of feminist and cognitive behavioral approaches delivered in a relatively unstructured, client-centered fashion. It is the only study to date that used random assignment to treatment versus no-treatment conditions. Based on police records, 31% of the control group and only 10% of the treated group showed evidence of repeat violence or serious threats during a one- to two-year follow-up period.³⁷

The third study evaluated several programs in Baltimore County, Maryland. The interventions varied in content, duration, and structure. Men who were court ordered to and successfully completed counseling programs were compared to men who went to court for domestic violence charges but were not referred to counseling. After statistical adjustment for pretreatment group differences, the recidivism rates for treated and untreated men were not significantly different.³⁹

Regarding the relative effectiveness of different treatments, one study compared three counseling formats: an educational approach with lectures, videotapes, role-plays, and brief discussions about the dynamics of abusive behavior and strategies to change; a minimally structured self-help group in which a former batterer helped clients discuss self-generated topics including personal responsibility, the use of "time out," and information about the cycle of violence; and a combined model that used aspects of the educational and self-help formats. The agency offered these formats sequentially, so that assignment to treatments was reasonably random. Each of the three treatment models was offered in a 12-session (27-hour) format and a 32-session (72-hour) format. Overall, there were no significant differences among the three treatment formats on partner-reported violence during the six months after treatment. Although the differences were not significant, the 27-hour formats yielded somewhat lower violence recidivism rates than the 72-hour formats, and the structured educational format yielded somewhat lower recidivism than the self-help and combined formats. When threats were the outcome, the structured educational format was significantly more effective than the self-help and combined treatment formats.⁴⁰

In brief, the available research, although limited, supports the use of structured psychoeducational counseling about the dynamics of domestic violence, the effects of domestic violence, and strategies or skills to supplant violent behavior. It is important to consider the impact of counseling on other parties

as well, because battered women weigh their partner's treatment status in decisions to return after separation.⁴¹ If counseling does not reduce violence, it may provide a dangerous illusion of safety.

Other clinical concerns

Detection of abuse. The initial detection of abuse can be difficult. A pervasive sense of shame and denial often envelops both perpetrators and victims, many of whom fear that the family will dissolve or that the perpetrator will be harshly punished if the abuse is made public. Others simply accept physical violence as a part of "normal" family life. Mental health practitioners should ask direct questions about spousal abuse in confidential interviews with each spouse. Structured questionnaires are also available.⁴² Although individuals rarely identify abuse spontaneously, most will report it when asked directly. In one marriage clinic, for example, only 6% of wives spontaneously listed physical abuse as a presenting problem. With direct interview questions, 44% of these wives reported physical abuse in the marriage. On a self-report questionnaire, 53% reported physical abuse in the previous year.⁴³

Diagnostic issues. The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*⁴⁴ includes a special code labeled "physical abuse of adult" under the category Other Conditions That May Be a Focus of Clinical Attention (also known as *v*codes, for which some insurance companies will not cover services). Many batterers meet the criteria for intermittent explosive disorder, which involves repeated episodes of assault or destruction of property out of proportion to precipitating stressors that cannot be accounted for by another mental disorder, physiological effects of a substance, or a general medical condition. Differential diagnoses for intermittent explosive disorder include antisocial personality disorder, borderline personality disorder, a psychotic disorder, or a manic episode. The base rates of these various disorders among domestic violence perpetrators, and the rates of domestic violence among individuals with these various disorders, have not been adequately studied.

The extent to which treatment for any of these associated diagnoses will alleviate domestic violence remains an open question. Most practitioners recommend specific services for domestic violence whether or not major mental disorders are present, provided the individual is in a state of mind to benefit from counseling. Adjunctive services for substance abuse or other problems are often recommended or required for acceptance into a domestic violence program.

Fears about intervening. Professionals are sometimes reticent about intervening in domestic violence cases out of fear that the situation might become more dangerous. This reaction

is understandable. Many batterers are intimidating and capable of severe violence. Available studies, however, suggest that community intervention and monitoring enhance victim safety. When professionals find out about domestic violence, failure to act can send a chilling message that the community is unwilling to intervene.

Summary and recommendations

Research on the demographic and psychological characteristics of domestic violence perpetrators has grown dramatically in the past 15 years. Research on the effectiveness of treatments for this problem, however, is very limited. Initial evidence supports the use of structured psychoeducational interventions with domestic violence perpetrators, but more research is sorely needed. Evaluation or treatment must occur with the recognition that assaultive behavior is illegal and punishable under the law. Service providers should not protect violent offenders from the consequences of their actions, but should work in coordination with the criminal justice system to offer offenders help in changing their behavior. Clinical services for domestic violence offenders are an important component in a comprehensive community response to domestic violence that includes legal accountability, community education and primary prevention efforts, and comprehensive victim services.

References

1. Dobash RE, Dobash R. *Violence Against Wives: A Case Against the Patriarchy*. New York: Free Press; 1979.
2. Martin D. *Battered Wives*. New York: Pocket Books; 1976:32.
3. Levinson D. Family violence in cross-cultural perspective. In: Van Hasselt VB, Morrison RL, Bellack AS, Hersen M, ed. *Handbook of Family Violence*. New York: Plenum Press; 1987.
4. Strube MJ. The decision to leave an abusive relationship: empirical evidence and theoretical issues. *Psychol Bull* 1988;104:236–250.
5. Hotaling GT, Sugarman DB. An analysis of risk markers in husband-to-wife violence. *Violence Vict* 1986;1:101–124.
6. Murphy CM, Meyer SL, O'Leary KD. Dependency characteristics of partner assaultive men. *J Abnorm Psychol*. In press.
7. Holtzworth-Munroe A, Hutchinson G. Attributing negative intent to wife behavior: the attributions of maritally violent versus nonviolent men. *J Abnorm Psychol* 1993;102:206–211.
8. Coleman VK. Breaking the silence about lesbian battering: New directions in domestic violence theory. Presented at the annual meeting of the American Psychological Association, Washington, DC, August 1992.
9. Neidig PH, Friedman DH. *Spouse Abuse: A Treatment Program for Couples*. Champaign, IL: Research Press; 1984.
10. Cordova JV, Jacobson NS, Gottman JM, Rushe R, Cox G. Negative reciprocity and communication in couples with a violent husband. *J Abnorm Psychol* 1993;102:559–564.
11. Murphy CM, O'Leary KD. Psychological aggression predicts physical aggression in early marriage. *J Consult Clin Psychol* 1989;57:579–582.
12. Schwartz MD. Gender and injury in spousal assault. *Sociological Focus* 1987;20:61–74.
13. Suitor JJ, Pillemer K, Straus MA. Marital violence in life course perspective. In: Straus MA, Gelles RJ, ed. *Physical Violence in American Families*. New Brunswick, NJ: Transaction; 1990:305–317.
14. Cazenave NA, Straus MA. Race, class, network embeddedness, and family violence: a search for potent support systems. In: Straus MA, Gelles RJ, ed. *Physical Violence in American Families*. New Brunswick, NJ: Transaction; 1990:321–340.
15. Straus MA, Smith C. Violence in Hispanic families in the United States: Incidence rates and structural interpretations. In: Straus MA, Gelles RJ, ed. *Physical Violence in American Families*. New Brunswick, NJ: Transaction; 1990:341–368.
16. Murphy CM, Cascardi M. Psychological aggression and abuse in marriage. In: Hampton RL, Gullotta TP, Adams GR, Potter EH, Weissberg RP, ed. *Family Violence Prevention and Treatment*. Beverly Hills, CA: Sage; 1993:86–112.
17. Tolman RM, Bhosley G. The outcome of participation in a shelter-sponsored program for men who batter. In: Knudsen D, Miller J, ed. *Abused and Battered: Social and Legal Responses to Family Violence*. New York: Aldine de Gruyter; 1991:113–122.
18. Kantor GK, Straus MA. The “drunken bum” theory of wife beating. In: Straus MA, Gelles RJ, ed. *Physical Violence in American Families*. New Brunswick, NJ: Transaction Press; 1990:203–224.
19. Murphy CM, O'Farrell TJ. Factors associated with marital aggression in male alcoholics. *J Family Psychol*. In press.
20. Leonard KE. Drinking patterns and intoxication in marital violence: review, critique and future directions for research. In: U.S. Department of Health and Human Services, *Research Monograph 24: Alcohol and Interpersonal Violence: Fostering Multidisciplinary Perspectives* (NIH Publication No. 93-3496). Rockville, MD: National Institutes of Health; 1992:253–280.
21. DeMaris A, Jackson JK. Batterers' reports of recidivism after counseling. *Social Casework* 1987;68:458–465.
22. Hamberger LK, Hastings JE. Recidivism following spouse abuse abatement counseling: treatment program implications. *Violence Vict* 1990;5:157–170.
23. O'Farrell TJ, Murphy CM. Marital violence before and after alcoholism treatment. *J Consult Clin Psychol*. In press.
24. Murphy CM, Meyer SL, O'Leary KD. Family of origin violence and MCMI-II psychopathology among partner assaultive men. *Violence Vict* 1993;8:165–176.
25. Goldstein D, Rosenbaum A. An evaluation of the self-esteem of maritally violent men. *Family Relations* 1985;34:425–428.
26. Dutton, DG. *The Domestic Assault of Women*. Newton, MA: Ally and Bacon, 1988.
27. Maiuro RD, Cahn TS, Vitaliano PP, Wagner BC, Zegree JB. Anger, hostility, and depression in domestically violent versus generally assaultive men and nonviolent control subjects. *J Consult Clin Psychol* 1988;56:17–23.
28. Rosenbaum A, Hoge SK. Head injury and marital aggression. *Am J Psychiatry* 1989;146:1048–1051.
29. Volavka J. *Neurobiology of Violence*. Washington, DC: American Psychiatric Association. In press.
30. Virkunen M, Rawlings R, Tokola R, Poland RE, Guidotti A, Nemeroff C, et al. CSF Biochemistries, glucose metabolism, and diurnal activity rhythms in alcoholic, violent offenders, fire setters, and healthy volunteers. *Arch Gen Psychiatry* 1994;51:20–27.

31. Tardiff K, ed. Violence and the violent patient. *American Psychiatric Association Annual Review*. Vol. 6. Washington, DC: American Psychiatric Press, 1987.
32. Saunders DG. A typology of men who batter: three types derived from cluster analysis. *Am J Orthopsychiatry* 1992;62:264-275.
33. Rosenbaum A, Maiuro RD. Perpetrators of spouse abuse. In: Ammerman RT, Hersen M, ed. *Treatment of Family Violence*. New York: John Wiley and Sons; 1986:280-309.
34. Paymar M, Pence, E. *Education Groups for Men Who Batter: The Duluth Model*. New York: Springer; 1993.
35. Bograd M. Family systems approaches to wife battering: a feminist critique. *Am J Orthopsychiatry* 1984;54:558-568.
36. Rosenfeld BD. Court-ordered treatment of spouse abuse. *Clin Psychol Rev* 1992;12:205-226.
37. Palmer SE, Brown RA, Barrera ME. Group treatment program for abusive husbands: long-term evaluation. *Am J Orthopsychiatry* 1992;62:276-283.
38. Dutton DG. The outcome of court-mandated treatment for wife assault: a quasi-experimental evaluation. *Violence Vict* 1986;3:163-175.
39. Harrell A. *Evaluation of Court-Ordered Treatment for Domestic Violence Offenders: Final Report*. Washington, DC: The Urban Institute; 1991.
40. Edelson JL, Syers M. Relative effectiveness of group treatments for men who batter. *Social Work Research and Abstracts* 1990;26:10-17.
41. Gondolf EW. The effect of batterer counseling on shelter outcome. *Journal of Interpersonal Violence* 1988;3:275-298.
42. Straus MA. Measuring intrafamily conflict and violence: the Conflict Tactics Scales. *Journal of Marriage and Family* 1979;41:75-88.
43. O'Leary KD, Vivian D, Malone J. Assessment of physical aggression against women in marriage: the need for multimodal assessment. *Behavioral Assessment* 1992;14:5-14.
44. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994:612,682. ■

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Domestic homicide: risk assessment and professional duty to warn

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ABSTRACT: *Battering has been associated with increased risk of homicide in the home. Homicide involving partners in a current or past intimate relationship may not have the same characteristics as other homicides. Physicians, nurses, and other health care professionals—who frequently see battered women as patients—should understand the dynamics, risk factors, and legal responsibilities related to domestic homicide in order to help prevent this form of violence.*

Homicide of women, along with other forms of violence, has only recently been defined as a health care problem. Homicide is the seventh leading cause of premature death for women overall in the United States¹ and the leading cause of death for African American women ages 15-34.² Since 1940, other causes of death among women have been reduced, but death by homicide has increased. In one urban county, homicide was the leading cause of maternal mortality (deaths occurring during pregnancy or within 90 days of its termination by birth or otherwise) from 1986 to 1989.³

There are marked differences in the dynamics of homicide of women and men: women are most often killed by a husband, lover, or ex-husband or ex-lover, and wife abuse usually precedes the death.⁴ Approximately half as many husbands are killed as wives, with wife abuse also precipitating those homicides.^{5,6} Kellerman and his associates found that a history of domestic violence increases the risk of homicide in the home by 4.4.⁷ Other risk factors for domestic homicide (of and by women of and by their intimate partner in a current or prior relationship) are not yet firmly established by research, although there have been several retrospective studies of homicide involving female partners. Because battering is clearly the most important risk factor, however, there is both a legal and ethical mandate that abused women seen in the health care system be made aware of their risk of homicide.

Assessing risk for domestic homicide

A number of investigators have reported factors that may be associated with increased risk of domestic homicide.

According to Hart,⁸ factors to be considered when assessing lethality include

- ☐ threats of homicide or suicide;
- ☐ fantasies of homicide or suicide;
- ☐ presence of weapons;
- ☐ obsessiveness about partner;
- ☐ batterer's isolation from support systems other than the victim;
- ☐ rage, depression, drug or alcohol consumption;
- ☐ access to the battered woman.

Although Hart suggests that the first two factors are primary and the rest less important, there is no statistical support for these factors.

Straus⁹ criteria for identifying life-threatening risk among violent men are based on the 1985 National Family Violence Survey. The criteria are associated with severe violence as measured on the Conflict Tactics Scale (CTS) and thus have concurrent construct validity support from a nationally representative sample.²² In addition to three or more instances of violence in the previous year, Straus' criteria include three or more of the following:

- ☐ the man initiated the two most recent instances of violence;
- ☐ the wife needed medical treatment as a result of the abuse;
- ☐ police were involved in an incident in the previous 12 months;
- ☐ the man was drunk more than three times a year, abused drugs in the past year, threatened to kill,

threatened with a weapon in hand, owns a gun and threatened to use it;

- ☐ extreme male dominance or attempts to achieve such dominance;
- ☐ physical abuse of a child;
- ☐ belief that there are situations when it is ok for a man to hit his wife;
- ☐ physically forced sex;
- ☐ extensive destruction of property;
- ☐ threatened or actual injury or killing of a pet;
- ☐ history of psychological problems;
- ☐ assault of a non-family person or other violent crime;
- ☐ severe violence between parents;
- ☐ verbally aggressive to partner (CTS verbal aggression score of 40+).

Based on their clinical experience, Sonkin and colleagues¹⁰ list the following under the homicide risk category in their batterer's assessment of lethality factors:

- ☐ weapons in the home;
- ☐ use of weapons in prior abusive incidents;
- ☐ threats with weapons;
- ☐ threats to kill;
- ☐ serious (life-threatening) injury in prior abusive incidents.

They also list 13 other lethality factor categories: suicide risk, frequency/cycle of violence, history of violence, substance use/abuse, assaults on other family members, previous criminal history/activity, violence outside the home, isolation, proximity of victim and offender, attitudes toward violence, life stresses, general mental functioning, physical health, and therapist's evaluation. Each category is explained with further assessment probes rather than as a definitive risk factor. There has been no psychometric evaluation of this list.

The lists reviewed above concentrate on risk factors for male batterers' killing their female partners. An abused woman, however, also may kill her abuser. Browne's¹¹ list of factors that in her sample differentiated battered women who killed their abusers from those who did not is often presented as a risk factor list. Although Browne's list was developed from a discriminant groups validity study, it has not yet been substantiated in subsequent research with independent samples. Factors on the list are the frequency of violent incidents, the severity of injuries, the man's threats to kill, the woman's threats of suicide, the man's drug use, the man's frequency of intoxication, and forced sexual acts.

Table 1 summarizes the risk factors that have been identified across the majority of these lists. Additional domestic homicide risk factors may include prior assault on an intimate

Table 1. Risk factors for homicide

- ☐ Access to/ownership of guns
- ☐ Use of weapons in prior abusive incidents
- ☐ Threats with weapons
- ☐ Threats to kill
- ☐ Serious injury in prior abusive incidents
- ☐ Threats of suicide
- ☐ Drug or alcohol abuse
- ☐ Forced sex with female partner
- ☐ Obsessiveness
- ☐ Extreme jealousy
- ☐ Extreme dominance

Table 2. Danger Assessment

Several risk factors have been associated with homicide (murder) of both batterers and battered women in research which has been conducted after the killings have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation. (The "he" in the questions refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

- A. Using the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how long each incident lasted in approximate hours and rate the incident according to the following scale:
1. Slapping, pushing; no injuries and/or lasting pain
 2. Punching, kicking; bruises, cuts and/or continuing pain
 3. "Beating up"; severe contusions, burns, broken bones
 4. Threat to use weapon; head injury, internal injury, permanent injury
 5. Use of weapon; wounds from weapon
- (If any of the descriptions for the higher number apply, use the higher number.)
- B. Answer these questions yes or no
1. Has the physical violence increased in frequency over the past year?
 2. Has the physical violence increased in severity over the past year and/or has a weapon or threat with weapon been used?
 3. Does he ever try to choke you?
 4. Is there a gun in the house?
 5. Has he ever forced you into sex when you did not wish to do so?
 6. Does he use drugs? By drugs I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack," street drugs, heroin, or mixtures.
 7. Does he threaten to kill you and/or do you believe he is capable of killing you?
 8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
 9. Does he control most or all of your daily activities? (For instance, does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? If he tries, but you do not let him, check here.)
 10. Have you ever been beaten by him while you were pregnant? (If never pregnant by him, check here.)
 11. Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can.")
 12. Have you ever threatened or tried to commit suicide?
 13. Has he ever threatened or tried to commit suicide?
 14. Is he violent toward your children?
 15. Is he violent outside of the home?

Total Yes Answers _____

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

partner (regardless of whether the partner is a spouse);¹² women's economic dependency (reflective of coercive control),¹³ and male control.¹⁴

The Danger Assessment

To date, no list of homicide risk factors in battering relationships has well established psychometric data, "cutoff" scores, or determination of the relative risk of various factors. The Danger Assessment (**Table 2**), an instrument developed from retrospective research on homicide involving women, has the most published data thus far, but no predictive validity information. In the five research projects in which it has been used, reliability ranged from 0.60 (in a very small sample) to 0.86.¹⁵ In two studies in which test-retest reliability was assessed, it ranged from 0.89 to 0.94. All samples included a substantial proportion of African American women and women from a variety of settings; reliability estimates did not differ significantly between African American and European American women. Convergent construct validity of the Danger Assessment is supported by moderately strong correlations with instruments that measure severity and/or frequency of abuse: the Conflict Tactics Scale,¹⁶ the Index of Spouse Abuse, and a rating of severity of worst injury incurred as a result of the abuse. Concurrent predictive validity (group differentiation) of the Danger Assessment is supported by the finding of different mean scores in seven different groups of abused women, reflecting differing degrees of abuse severity that would be expected in the different populations: lowest scores were in the non-abused sample, followed by the prenatal sample, women in the community, women in shelters, and women in a hospital emergency room.

The Danger Assessment was originally developed as a clinical instrument to help women assess their own risk of homicide. The woman can complete the instrument by herself while the health care professional fulfills other responsibilities. Because the Danger Assessment has no established cutoff scores, women are encouraged to interpret their scores in their own frame of reference. A calendar of the previous year is used to help determine if the abuse has increased in severity and frequency. The woman is asked to mark the approximate days when physically abusive incidents occurred, to estimate the amount of time the incident lasted, and to rank the incident on the scale presented on the Danger Assessment. Most women have no problem filling out the calendar; they remember these incidents very well. In the instrument development studies, up to 38% of women changed their answers from no to yes on at least one question about increased frequency or severity after marking a calendar.¹⁵ Thus, it may help women penetrate the minimization that most use to deal with their abuse.

In addition to homicide risk, appropriate lethality assessments with battered women include a suicidality assessment. Depression is the most common mental health consequence of battering and that woman abuse has been identified as a significant risk factor for female suicide is congruent with that finding.^{17,18} If the Danger Assessment is being used for homicide assessment, the suicide ideation and history item can serve as an initial screen for suicide risk. If depressed affect is present, a more thorough assessment is indicated.

Clinical implications

Patients (women or men) with a history of any of the factors listed in **Table 1** should have a more complete homicide risk assessment. Whether the Danger Assessment or another list of risk factors is used, it is important to document any factors that are present as well as the fact that a lethality assessment was conducted.

Because there are no absolute predictors with any of the risk factor lists, the woman must make the ultimate determination of degree of risk. The discussion itself can be an extremely useful intervention in helping an abused woman weigh the relative risks and benefits of the relationship. Helping her make a safety plan is useful in any battering situation, but more crucial when the risk of homicide is substantial. The discussion should include strategies for having essential documents, belongings, and a substantial amount of cash available for a quick exit; helping children understand what to do in an emergency; and planning a destination (e.g., wife abuse shelter). If there is a gun in the home, it is imperative to discuss the possibility of disarming it, having it impounded by the police, or at least keeping it locked up and unloaded so that it is not easily picked up in anger.

Duty to warn

A number of court decisions over the past 20 years have held clinicians negligent for not adequately predicting dangerousness, protecting patients as potential victims, and in some states providing warnings to potential victims of patients.⁸ Legal experts generally agree that if a therapist concludes that a patient is a serious danger to someone else, the therapist must warn the potential victim.¹⁹ The mandate is especially pertinent when therapists counsel couples or conduct treatment groups for batterers because of the demonstrated risk of homicide in battering relationships. Thus, all couple counseling should include separate abuse assessment with each partner and, if abuse is found, assessment for homicide potential. Homicide potential also must be assessed in batterer treatment groups regardless of whether the batterer is still living with the abused partner; ex-husbands are known to be potentially lethal

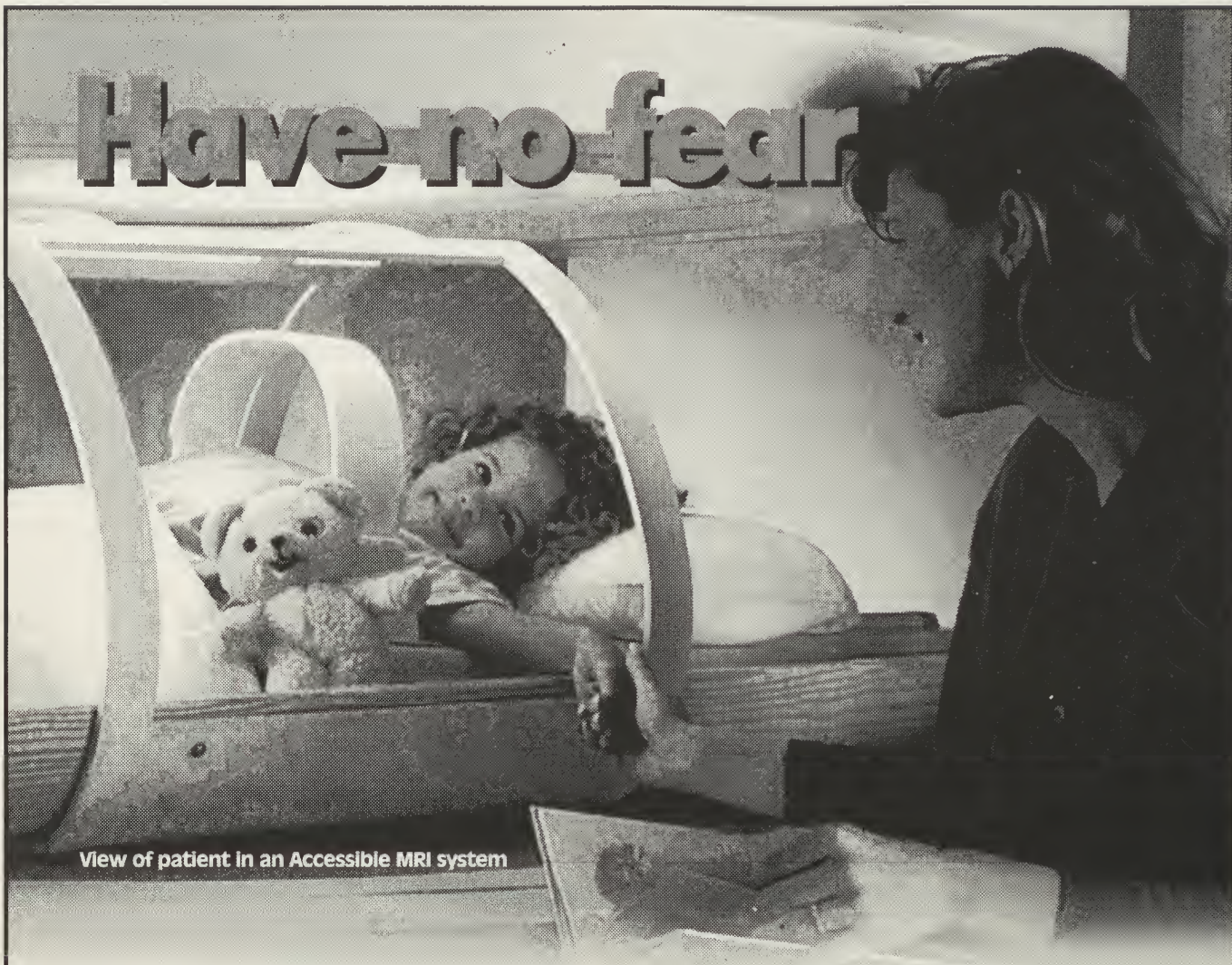
to wives they formerly abused.² When clinicians judge homicide potential to be high, they must notify both the abused partner and the police and/or parole officer; in such cases, the law is clear that the duty to warn takes precedence over confidentiality.

Although the "duty to warn" is less clear when the patient is the potential victim, knowing that battered women may be at increased risk of homicide presents an ethical mandate for health care professionals similar to that of warning smokers of their risk of mortality from cancer and heart attack. Many experts now include a lethality assessment and safety plan as part of the standard of care for identified domestic violence victims.

References

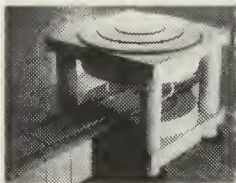
1. *Healthy People Two Thousand: National Health Promotion and Disease Prevention Objectives*. Washington, DC: Department of Health and Human Services; 1990.
2. Farley R. Homicide trends in the United States. In Hawkins DF, ed. *Homicide Among Black Americans*. New York: University Press of America; 1986:13-27.
3. Fildes J, Reed L, Jones N, Marcel M, Barrett J. Trauma: the leading cause of maternal death. *J Trauma* 1992;32:643-645.
4. Loya F, Mercy JA. *The Epidemiology of Homicide in the City of Los Angeles, 1970-1979*. University of California at Los Angeles and Centers for Disease Control, Department of Health and Human Services, Public Health Service, Centers for Disease Control; 1985.
5. Campbell JC. "If I can't have you, no one can": power and control in homicide of female partners. In Radford J, Russell D, ed. *Femicide: The Politics of Woman Killing*. Boston, MA: Twayne; 1992.
6. Kellermann AL, Mercy JA. Men, women and murder: gender-specific differences in rates of fatal violence and victimization. *J Trauma* 1992;33:1-5.
7. Kellerman A, Rivara FP, Rutherford NB, Blanton JF, Reay DT, Francisco JT, et al. Gun ownership as a risk factor for homicide in the home. *N Engl J Med* 1993;329:1084-1091.
8. Hart B. Beyond the "Duty to Warn": a therapist's "Duty to Protect" battered women and children. In Yllo K, Bograd M, ed. *Feminist Perspectives on Wife Abuse*. Newbury Park, CA: Sage; 1988:234-248.
9. Straus MJ. Severity and chronicity of domestic assault: measurement implications for criminal justice intervention. Presented at the annual meeting of the American Society of Criminology, San Francisco, CA, November 1991.
10. Sonkin DJ, Martin D, Walker LE. *The Male Batterer: A Treatment Approach*. New York: Springer; 1985.
11. Browne A. *Battered Women Who Kill*. New York: Free Press; 1987.
12. Saltzman L, Mercy J, O'Carroll P, Rosenberg M, Rhodes P. Weapon involvement and injury outcomes in family and intimate assaults. *JAMA* 1992;267:43-47.
13. Jurik NC, Winn R. Gender and homicide: a comparison of men and women who kill. *Violence Vict* 1990;5:227-242.
14. Rasche C. Stated and attributed motives for lethal violence in intimate relationships. Presented at the annual meeting of the American Society of Criminology, Reno, NV, 1989.
15. Campbell JC. Prediction of homicide of and by battered women. In Campbell J, ed. *Assessing Dangerousness: Potential for Further Violence of Sexual Offenders, Batterers, and Child Abusers*. Newbury Park, CA: Sage; 1994.
16. Okun LE. *Woman Abuse: Facts Replacing Myths*. Albany, NY: SUNY Press; 1986.
17. Campbell JC. A test of two explanatory models of women's responses to battering. *Nurs Res* 1989;38:18-24.
18. Stark E, Flitcraft A, Van Hasselt VB. Violence among intimates: an epidemiological review. In Van Hasselt VB, ed. *Handbook of Family Violence*. New York: Plenum; 1987.
19. Small LB. Psychotherapists' duty to warn: ten years after Tarasoff. *Golden Gate University Law Review* 1985;15:271-300.

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I N N O V A T I O N A N D C O M F O R T F O R Y O U

Joint Commission on Accreditation of Healthcare Organizations standards to improve care for victims of abuse

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The 1995 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for victims of abuse¹ provide an excellent framework for the continuous improvement of a health system's response to victims of abuse and violence. This article focuses on how the standards apply to victims of domestic violence and answers the following questions:

- What is the JCAHO and what are the 1995 JCAHO standards for victims of abuse (including victims of domestic violence)?
- How have JCAHO standards for victims of abuse evolved? How do they differ from related standards in previous years?
- For whom are the standards applicable? What are the implications for individual members of healthcare organizations?
- How does substantial compliance with the standards enable a health care organization to provide better care for victims of domestic violence?
- What resources are available to help organizations meet JCAHO standards?

The JCAHO and its 1995 standards for abuse victims

The mission of the JCAHO is to improve the quality of health care delivered to the public. A private, not-for-profit organization, JCAHO evaluates the performance of nearly 9,000 health care organizations. Member organizations of JCAHO are the American College of Physicians, American College of Surgeons, American Dietetic Association, American Hospital Association, and American Medical Association. The JCAHO board includes representatives from member organizations, nursing professionals, and representatives of the public at large.²

Through a voluntary accreditation process, the JCAHO educates, consults on, and evaluates structures, processes, and outcomes that enable the delivery of quality health care. There are specific accreditation programs for hospitals, home health care, ambulatory care, health care networks, mental health, and long-term care. Furthermore, standards (guidelines), which are

Table 1. JCAHO 1995 standards for suspected victims of abuse*

| Standard number | |
|-----------------|---|
| PE.1.9 | Possible victims of abuse are identified using criteria developed by the organization. |
| PE.6 | The assessment of victims of alleged or suspected abuse or neglect |
| PE.6.1 | is conducted with the consent of the patient or parent or legal guardian, or as otherwise provided by law; |
| PE.6.2 | is conducted in accordance with the organization's responsibility for the collection, retention, and safeguarding of evidentiary material released by the patient; |
| PE.6.3 | includes, as legally required, the notification and release of information to the proper authorities. |
| LD.2.1 | Department directors are responsible, either personally or through delegation for |
| LD.2.1.8 | orienting and providing in-service training and continuing education of all persons in the department. |
| HR.3.2 | A staff orientation process provides initial job training and information, including an assessment of an individual's capability to perform specified responsibilities. |

* Reference 1

a key element in the accreditation process, have evolved to be *descriptive* rather than *prescriptive*. Standards allow unique health care organizations to develop organizational- and service-specific policies and procedures. The standards are developed and refined from critical analysis of the literature, the health care environment, and recommendations from performance technical advisory committees (PTACs). The PTACs are composed primarily of individuals selected by professional organizations and one public member. The 1995 JCAHO standards that relate to the care of abuse victims are shown in **Table 1**.

Evolution of the standards for abuse victims

Until recently, most research involving recognition and management of domestic violence victims in health care settings was conducted in hospital emergency departments (EDs), which often provide battered women the first opportunity to find support, assistance, medical care, and protection.³⁻⁷ In its 1989 report *Healthy People 2000*, the U.S. Department of Health and Human Services^{8,9} identified among national public health priorities the production of baseline data on the number of EDs that use domestic violence protocols and the extension of protocols for identifying, treating, and properly referring victims of spouse abuse. The goal was to establish protocols to address domestic violence in at least 90% of the nation's hospital EDs.

In 1992, JCAHO added physical assault and "domestic abuse of elders, spouses, partners" to the existing standards for child abuse, rape, and sexual molestations. Compliance with these

standards focused on policies, procedures, and activities that could be assessed primarily in the ED of health care organizations (JCAHO Emergency Services Standards).¹⁰ Through 1993, hospitals had to define emergency physicians' "scope and conduct" of care for abuse victims. Policies had to address procedures for "victim identification, patient consent, examination and treatment; the hospital's responsibility for the collection, retention, and safeguarding of specimens, photographs, and other evidentiary material; and, as legally required, notification of and release of information to the proper authorities." Standards also addressed staff education and medical records and required that a list of referral agencies be maintained.¹¹

Results from a survey study published in 1993 highlighted key deficiencies in one state's ED response to domestic violence,^{12,13} and compliance with JCAHO standards was assessed. Response rate was high: 87% of California hospitals responded (216 responses from physician directors and 319 from nurse managers). According to survey results, however, only one in four EDs had conducted educational sessions on domestic violence: 23% of physician directors reported that their ED had conducted an educational session on domestic violence for physicians; only 6% of such sessions were for residents. Of the nurse managers, 28% reported that their hospital had conducted an educational session for all ED staff.

The survey also indicated that ED staff did not see themselves as obstacles to identification. Both nurse managers and physician directors perceived patient factors (such as the patient's fear of repercussion, denial, failure to volunteer

Table 2. Evolution of JCAHO standards to improve care for victims of abuse

| | 1992* | 1993 | 1994 | 1995 |
|---|-----------------------|-----------------------|--|--|
| Standard Number | ES4.1.2.9 - 4.1.2.9.5 | ES4.1.2.9 - 4.1.2.9.5 | ES4.1.2.9 - 4.1.2.9.5 PE6.0 - 6.3 PE1.9 | HR3.2 LD2.1.8 PE6.0 - 6.3 PE1.9 |
| Standard "Weight" ¹ | A/Score 5 | A/Score 5 | A/Score 5 | A/Score 5 |
| Organizational sites surveyed for compliance | ED | ED | Organization wide - at sites of patient assessment Education for ED Staff | Organization wide Across Functions ² |
| Specific elements - care: | | | | |
| • Department directors are responsible for providing orientation, in-service and continuing education for all persons in the department | No | No | No | Yes |
| • Victim identification by <i>organization specific criteria</i> for physical assault, rape or other sexual molestation, domestic abuse, abuse of elders and children | Yes | Yes | Yes | Yes |
| • Criteria must be OBJECTIVE | No | No | No | Yes |
| • Education of appropriate staff | No | No | Yes | Yes |
| • Initial orientation/education of appropriate staff | No | No | No | Yes |
| • Assessment of new staff capability to perform responsibilities after orientation | No | No | No | Yes |
| Assessment of victims of alleged or suspected abuse is conducted: | | | | |
| • with consent | Yes | Yes | Yes | Yes |
| • in accordance with organization's responsibility | Yes | Yes | Yes | Yes |
| • notification of and release of information to proper authorities | Yes | Yes | Yes | Yes |
| Medical Records include appropriate documentation | Yes | Yes | Yes | Yes |
| List maintained and appropriate referrals made to community agencies that provide or arrange for care | Yes | Yes | N/A ³ | N/A ³ |

* Standards addressing sexual molestation, rape and child abuse have been in place since 1981.

1. Range of scores is 1-5. Score 5 indicates lack of appropriate organizational specific policies and practices — non-compliance.

2. 1995 Standards are performance based and functional. Care of a patient is continuous when receiving care. JCAHO has described eleven functions; three which have standards explicitly related to provision of care for victims of domestic violence.

3. Functional Standards were designed to eliminate prescriptive "paperwork" details. It is assumed that lists of agencies for referral will still be available on site as a part of the care process.

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Table designed by C.J. Scott, M.D.

information, and use of drugs or alcohol) to be the greatest barriers to the identification of battering. Survey respondents cited these factors most frequently as major obstacles to identification and least frequently as factors not considered a problem. Of survey respondents, 50% cited as a major problem the fact that patients did not mention battering during the history-taking (although research indicates that battered women are likely to respond to health care providers who ask questions about possible abuse).

According to survey results, many referral lists and brochures did not address the specific needs of battered women. Of the nurse managers, 295 (93%) reported that their EDs had referral lists for battered patients (135 returned a copy of the list). All lists were reviewed to determine the kinds of services represented (including domestic violence shelters or agencies, criminal justice agencies, general social services, mental health or community agencies). Only 9 hospitals (7%) returned lists that included information in all categories. Respondents (92%) indicated that patients were referred most often to battered women's shelters or domestic violence programs; only 17% of nurse managers reported that referrals were made to private attorneys or legal assistance agencies.

Of the 110 ED policies submitted by nurse managers, only 59 (54%) were specific to partner/spouse abuse; the rest addressed other forms of abuse (elder, child, sexual, etc.) or general criminal assault. The 59 submitted policies that specifically addressed domestic violence were examined for elements required by JCAHO in 1993. Of these, 58% addressed notification of authorities; 34%, how to conduct a physical exam; 24%, the taking of photographs; and 19%, the gathering of physical evidence. Only 14% provided guidance on what to put in the medical record regarding the physical examination, treatment, referrals, and/or notification of authorities.

In 1994, JCAHO introduced "patient focused/performance based/functional" standards. These standards require that assessment and care of abuse victims be performed with consistency in all settings within a health care organization.¹⁴ The transition to "patient focused/performance based/functional" standards is a part of the JCAHO's "Agenda for Change" initiative (discussed below). Organizations must have an education plan that includes identification of all staff in any location who should be educated on criteria for identifying possible victims of abuse and the medical and legal procedures that should be followed. Documentation in all medical records must be consistent with organization policies related to all activities in identification, treatment, consent, responsibility for evidentiary material, and referral. In 1994, all sites for which the organization is responsible for patient assessment and the ED are sites for compliance (JCAHO Emergency Services and Patient Assessment Standards).

In 1995, the entire health care organization is responsible for maintaining compliance with the standards related to victims of abuse. There are no emergency services (ES) standards (see **Tables 1 and 2**). Standards are to be in place across departments (i.e., the standards are functional). This shift represents greater appreciation of the need to recognize and manage domestic violence victims across departmental settings in the hospital. Recent studies indicate that: 1) battered women compose 25% to 30% of women seeking medical care *for any reason*; 2) of women seen in ambulatory care clinics, 14% to 28% are victims of abuse; and 3) of women seeking routine prenatal care, 23% are victims of abuse.¹⁵⁻¹⁸

The completion of this transition in the content and format of the 1995 standards, including those relevant to victims of abuse, reflects an evolution in the general characteristics of the overall JCAHO accreditation process. This "Agenda for Change" is a set of major developmental initiatives designed to make continuous improvement in patient outcomes and organizational performance the central and explicit objective of JCAHO accreditation activities.

In 1995, JCAHO standards are framed as performance objectives that focus on important functions, performance, and performance improvement. Three types of important functions that have been described are 1) patient focused; 2) organizational; and 3) structural. Care for victims of abuse requires collaboration and coordination across all three types of functions. The standards revision process was based on the premise that health care organizations exist to maximize the health of all the people they serve and to use resources efficiently. Existing standards were revised and new standards developed to emphasize evaluation of hospital performance aimed at continuously improving the outcomes of patient care. The new standards allow greater flexibility for specific organizations to develop compliance.

Implications for individual members of health care organizations

All individuals (physicians, nurses, triage staff, etc.) who may be involved in the hospital-based assessment, re-assessment, and care of patients are subject to the intent of the JCAHO standards for abuse victims. For example, based on hospital-developed criteria, appropriate individuals must know objective criteria for identification and care of victims of abuse—including victims of domestic violence. Organization-wide *functional performance-based standards* for suspected victims of abuse can also be found in the ambulatory and network accreditation programs. *Non-functional standards*, which guide care of victims of abuse in other settings, currently exist in the Long-Term Care, Home Health Care, and Mental Health accreditation programs. The transition to performance-

Table 3. Standard, intents, and examples of implementation*

| Standard | Intent | Examples of implementation |
|----------|--|--|
| HR.3.2 | <p>Each staff member's capability to perform his or her specific job responsibilities is assessed through the completion of an orientation process. The orientation process is designed to promote the safe and effective performance of staff members' responsibilities and familiarize them with their responsibilities and/or work environment before initiating patient care and/or other activities.</p> <p>Note: When the organization uses volunteer services, those individuals are oriented to patient care, safety, infection control, and any other activities in which they are expected to perform in a competent manner.</p> | <p>The organization can produce individual employee records of attendance and completion of the organization-wide orientation program and an individual department-specific or job-specific program. The evidence includes each employee's required competencies and the measures used to assess those competencies.</p> <p>In a small, inner city hospital with a hospital-based emergency service and hospital-sponsored urgent care center in the community, newly employed staff in emergency service areas receive an orientation related to their job responsibilities. For those individual staff members who are responsible for assessing and triaging patients in the emergency service areas, initial training is provided during their unit-specific orientation regarding the objective criteria (developed by the organization's leaders) to identify possible victims of alleged or suspected abuse or neglect. The initial competence assessment of these staff members includes demonstration of knowledge about and appropriate use of the criteria set and the ability to identify such patients in actual patient care situations.</p> |
| PE.1.9 | <p>Victims of alleged or suspected abuse or neglect may be admitted to the organization through various settings or services. Appropriate care cannot be provided unless suspected or alleged victims are identified and assessed. Assessing the care needs of the patient is aided by using established criteria that focus on objective evidence that is observable (as opposed to acting on allegation alone) to identify possible victims of abuse throughout the organization. Staff education plans regarding the organization's established criteria are in place in accordance with HR.3 to train staff in the identification and assessment of potential victims of alleged or suspected abuse or neglect.</p> <p>Maintaining a list of private and public community agencies that provide, or arrange for, an assessment and care for abuse victims assists the organization in making appropriate referrals.</p> <p>The objective criteria used address at least:</p> <ul style="list-style-type: none"> • physical assault, • rape or other sexual molestation, • domestic abuse, and, • abuse of elders and children. <p>When used appropriately, the criteria guide qualified staff members using the criteria as part of an assessment to avoid any action or question that could create false memories of abuse or "false memory syndrome" in the individual being assessed.</p> | <p>If an adult presents to an urgent care service, and the actual injuries are not compatible with the account given (for example, x-rays show an unexplained broken bone), then the staff questions whether abuse may have occurred. Physical findings are compared to the hospital's approved procedure containing criteria that outline objective evidence of possible abuse or neglect.</p> <p>If a child presents to an emergency service, staff members look at who brought the child. Does the child cling to one parent and avoid the other? Staff members question the child in a nonthreatening manner, look for bruises on the body, and listen to explanations to see if there is compatibility between the physical evidence and the story.</p> |

* Reference 1

Table 3. Standard, intents, and examples of implementation

| Standard | Intent | Examples of Implementation |
|---|--|--|
| <i>PE.1.9</i> continued | In addition, the assessment of victims of alleged or suspected abuse or neglect is conducted in accord with standards PE.6 through PE.6.3. | |
| <i>PE.6</i> <i>through</i> <i>PE.6.3</i> | <p>Patients who are possible victims of alleged or suspected abuse or neglect have special needs relative to the assessment process. Information and/or evidentiary material(s) may be collected that could be used in future actions as part of the legal process. Therefore, the organization has specific and unique responsibilities for safeguarding such evidentiary material(s).</p> <p>Documentation in the patient's medical record needs to be consistent with organization policy and address the following items from PE.6.1 through PE. 6.3:</p> <ul style="list-style-type: none"> • Appropriate consents from patient, parent, or legal guardian, or as otherwise provided by law, are documented in the patient's medical record; • Organization policy outlines the responsibility for collecting, retaining, and safeguarding evidentiary materials released by the patient and for appropriate documentation in the patient's medical record; and • Assessment activities include, as legally required, notification of and release of such information to the proper authorities. | No examples cited. |
| <i>LD.2.1</i> <i>and</i> <i>LD.2.1.10</i> | <p>The leaders of each department are responsible for the department's continuous, effective operation and for the continuous improvement of its activities. Such responsibilities encompass not only the department's internal functioning, but also how it is integrated into the organization's overall functioning.</p> <p>A number of these responsibilities can be delegated to others in the department or within the organization. Responsibilities that may be appropriately delegated include, but are not limited to, developing and implementing department policies and procedures that guide and support the provision of services, gathering and analyzing data associated with the continuous improvement of the quality of care and services provided, and maintaining quality control programs. Although it may be appropriate for a director to delegate the work associated with a particular responsibility to a qualified individual, the director is ultimately responsible for all the activities listed in LD.2.1.1 through LD.2.1.10.</p> | <p>Organization leadership, including department directors in conjunction with the human resources department, formulated and approved a list of requirements that must be included in orientation of newly hired staff. The list includes organization-wide and department-specific topics. Mentors are assigned to provide training in accordance with their expertise. Evidence that orientation has been completed will be submitted to department directors.</p> <p>Intensive care staff, including laboratory, nursing, radiology, and respiratory care departments and services, have protocols for handling specific emergency conditions of patients including, for example, who may perform what special procedures, under what circumstances, and under what degree of supervision.</p> |

Table 3. Standard, intents, and examples of implementation

| Standard | Intent | Examples of Implementation |
|---|--|----------------------------|
| LD.2.1 and LD.2.1.10 continued | <p>Fulfilling these responsibilities enables the department to be integrated into the overall functioning of the organization, to coordinate its services with those of other services, and to continuously improve the services it provides.</p> <p>The leaders of each department need to make their particular resource needs known to the organization to ensure that there is an adequate supply of space, equipment, and other resources to meet patients' needs at all times. Patient care activities that require the use of special equipment, personnel, facilities, and/or services are performed only when appropriate resources are available. Equipment and supplies are suitable for all sizes of patients.</p> | |

based standards is expected to extend from hospital accreditation services to the other JCAHO accreditation programs by 1996. Thus, all health care settings and professionals will have conceptually similar standards that can guide education and performance to continuously provide improved services for domestic violence victims.

Substantial compliance

Table 3 shows the 1995 standards, their intent, and examples of implementation. Substantial compliance indicates an organization has appropriate *policies* and *practices* in place. It will be the process of organization self-assessment of the "system" that will enable true improvement in health care. Process analysis is a key element in continuously improving patient care.¹⁹⁻²¹ Compliance would be assessed during a survey process by patient and staff interviews, review of organizational policies and procedures, staff education, in-service records, and closed- and open-chart reviews. The JCAHO intends substantial compliance to enable an organization to provide appropriate, effective care for abuse victims.^{1,22}

Resources

The Medical and Chirurgical Faculty of Maryland, in conjunction with the Maryland Alliance Against Family Violence, has launched the Maryland Physicians' Campaign Against Family Violence (Physicians' Campaign). It is a three-part campaign focused on domestic violence, child abuse, and elder abuse. Each campaign segment will include a manual for health care professionals, a training session based on the manual, and educational resource materials.

The first module (domestic violence) is complete and a training session is being offered free of charge to all Maryland hospitals, HMOs, and other interested parties by the Physicians' Campaign. The training module includes a definition of domestic violence, barriers to identification, interviewing the patient, diagnosis and clinical findings, intervention, documentation, legal considerations in Maryland, and a resource list of domestic violence programs. The training module can play a critical role in an organization's continuous improvement of services to victims of domestic violence. (To schedule a training session on domestic violence, contact Rose Matricciani, R.N., J.D., Chief Operating Officer, Med Chi, at 410-539-0872 or 1-800-492-1056.)

Conclusion

Improving the quality of care to victims of abuse, including domestic violence victims, can occur by compliance with the 1995 JCAHO standards. A quick review of some of the national statistics on domestic violence provides a stark reminder of the necessity of medical intervention in the cycle of violence. Battered women account for:

- 22% to 35% of women seeking emergency services;
- 25% of all women who attempt suicide;
- 25% of all women seeking psychiatric emergency service;
- 45%-59% of mothers of abused children; and
- 58% of women over 30 years old who have been raped.²³

The 1995 JCAHO standards have provided the medical community with a framework for becoming involved in a

meaningful way in improving the delivery of services to victims of abuse. Compliance with the standards affords a coordinated approach to victims who interface with health care organizations.

References

1. Joint Commission on Accreditation of Healthcare Organizations. 1995 *Comprehensive Accreditation Manual for Hospitals*. vol. 1. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 1994:100-101, 120, 288-289, 365.
2. O'Leary D, Schyve P. The role of accreditation in quality oversight and improvement under healthcare reform. *The Quality Letter*, December 1993-January 1994:11-14.
3. Appleton W. The battered woman syndrome. *Ann Emerg Med* 1980;9:84.
4. McLeer SV, Anwar RAH, Herman S, Maquiling K. Education is not enough: A systems failure in protecting battered women. *Ann Emerg Med* 1989;18:651-653.
5. Stark E, Flitcraft A, Frazier W. Medicine and patriarchal violence: the social construction of a "private event." *Int J Health Serv* 1979;9:461-493.
6. McLeer SV, Anwar RAH. The role of the emergency physician in the prevention of domestic violence. *Ann Emerg Med* 1987;16:1155-1161.
7. McLeer SV, Anwar R. A study of battered women presenting in an emergency department. *Am J Public Health* 1989;79:65.
8. Public Health Service. *Healthy People 2000: National Promotion and Disease Prevention Objectives*. Washington, DC: U.S. Department of Health and Human Services; 1991 (DHHS publication no. PHS 91-50212).
9. Centers for Disease Control and Prevention. Emergency department response to domestic violence - California, 1992. *JAMA* 1993;270:1174-1176.
10. Joint Commission on Accreditation of Healthcare Organizations. 1992 *Accreditation Manual for Hospitals*. vol. 1. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 1991:21-22.
11. Joint Commission on Accreditation of Healthcare Organizations. 1993 *Accreditation Manual for Hospitals*. vol. 1. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 1992:20.
12. Centers for Disease Control and Prevention. Emergency department response to domestic violence - California, 1992. *MMWR Morb Mortal Wkly Rep* 1993;42:617-619.
13. Lee D, Letellier P, McLoughlin E, Salber P. California hospital emergency departments response to domestic violence—survey report. San Francisco, CA: Family Violence Prevention Fund; 1993.
14. Joint Commission on Accreditation of Healthcare Organizations. 1994 *Accreditation Manual for Hospitals*. vol. 1. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 1993:22.
15. Gin NE, Rucker L, Frayne S, Cygan R, Hubbell A. Prevalence of domestic violence among patients in three ambulatory care internal medicine clinics. *J Gen Intern Med* 1991;6:317.
16. MacFarlane J, Parker B, Soeken K, Bullock L. Assessing for abuse during pregnancy: severity and frequency of injuries and associated entry into prenatal care. *JAMA* 1992;267:317-318.

17. Campbell JC, Poland ML, Waller JB, Ager J. Correlates of battering during pregnancy. *Res Nurs Health* 1992;15:219-226.
18. Warshaw C. Domestic violence: challenges to medical practice. *Journal of Women's Health* 1993;2:73-80.
19. Berwick D. Continuous improvement as an ideal in health care. *N Engl J Med* 1989;320:53-56.
20. Kassirer J. The quality of care and the quality of measuring it. *N Engl J Med* 1993;329:1263-1264.
21. Joint Commission on Accreditation of Healthcare Organizations. *Framework for Improving Performance: From Principles to Practice*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 1994:1-36.
22. Tilden VP, Schmidt TA, Limandri BJ, Chiodo GT, Garland MJ, Loveless PA. Factors that influence clinicians' assessment and management of family violence. *Am J Public Health* 1994;84:628-633.
23. Maryland Physicians' Campaign Against Family Violence. *Module One: Domestic Violence*. Baltimore, MD: Medical and Chirurgical Faculty of Maryland; 1994.

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Legal protection for domestic violence victims: a guide for the treating physician

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The staggering dimensions of the problem of domestic violence have been well documented. Women and children are overwhelmingly the victims.¹ They come from all racial, ethnic, religious, and social-economic groups and from all age levels and educational backgrounds.² Battering by a spouse or intimate partner is the single largest cause of injury to women in the United States, greater than car accidents, rapes, and muggings combined.³ Each year, more than one million women seek medical treatment for injuries inflicted by a husband, ex-husband, or boyfriend.⁴ Studies estimate that 22% to 35% of women who visit emergency rooms do so for injuries directly inflicted by an intimate partner or for symptoms related to the stress of living in an abusive relationship.⁵

Effective and appropriate intervention includes developing protocols to identify victims, acknowledging the cause of their injuries, and providing them with information about legal and community resources. This article provides an overview of the civil and criminal law remedies available to victims of domestic violence in Maryland. Understanding both the benefits and limitations of the legal system's response to victims can help physicians provide appropriate follow-up information to patients and help prevent further injuries.

Legal remedies

A victim's first interaction with the legal system—often her first call for help to anyone—is usually an encounter with police in response to a 911 call. Although some police departments in Maryland have developed training and protocols to better protect victims of domestic violence, lack of such protocols or failure to follow them appears to be common. Effective October 1, 1994, law enforcement officers must give domestic violence victims written notice of services available in the community, including shelter, counseling, and their legal options available in Maryland's civil and criminal courts.⁶

Physicians and others who see victims of domestic violence on a regular basis must take an active role in providing these women with information about their rights. Physicians seeing victims in emergency rooms may be particularly well placed to supplement the information provided by police at the scene.

Initiating a criminal case. The first step for victims to ensure that the batterer is punished is to get a copy of the "incident report" that police make at the scene. If the police file an incident report, new legislation requires that a copy be provided to the victim upon request. If the police do not file an incident report, the victim should request that one be completed by going to her local police station and providing information about the incident. The police *must* prepare a report, which may be necessary if no arrest is made and the victim wants to file her own criminal charges.

The police may arrest a batterer at the scene if they have a warrant or "probable cause" to believe a violation of the law has occurred. The law regarding what constitutes probable cause is complex and depends, in part, on the level of injuries suffered by the victim and the victim's relationship to the abuser. Recent legislation has made it easier for police to arrest an alleged abuser without a warrant. The new law raises from two to 12 hours after an alleged battering the time within which the victim must make a report to police in order for the police to conduct a warrantless arrest.⁷ The time limit was extended based on advocates' testimony that a two-hour limit is unrealistic because victims are often detained for longer than two hours seeking medical care. In any event, victims should know that police have authority under some circumstances to make an arrest at the scene. When the police make an arrest, the victim need not take any further action before receiving a summons to testify.

If the police cannot or will not make an arrest, victims should know that *they* can initiate criminal charges by bringing a copy of the incident report to a court commissioner. Commissioners, located at each of the local district courts, review citizens' complaints and issue a criminal summons if they think, based on an interview with the victim and the incident report, that there is probable cause to believe a crime was committed. The victim will have to be firm and persistent, however, to initiate a criminal case.

Prosecution and trial of criminal charges. The effectiveness of the criminal justice system in protecting victims is limited by both the laws of the state of Maryland and the way they are implemented. Although Maryland has no specific "domestic violence" crime, a batterer may be prosecuted based on a variety of criminal statutes that should be equally applicable whether the offense is committed against a stranger or one's intimate partner. These include assault⁸ (threat or

attempted battery), battery⁹ (unjustified, offensive, and non-consensual application of force by direct or indirect physical contact with no requirement of physical injury), false imprisonment¹⁰ (deprivation of liberty without consent or justification), or child abuse.¹¹ Two relatively new laws also make criminal certain behavior often associated with batterers. Criminal harassment¹² includes a broad range of behavior, such as following the victim, or repeatedly going to the victim's home and/or workplace if these actions are done over a period of time, seriously annoy or alarm the victim, and are done for that purpose. The statute unfortunately carries very limited penalties. The crime of stalking carries much stiffer penalties, but the stalker's actions must be shown to have placed the victim or a third person in fear of serious injury or death.¹³

The law, however, creates some unfortunate barriers to prosecution. For example, until 1989, rape was not considered a crime in Maryland when the victim was married to the abuser. Even under the new marital rape statute, prosecution can occur only when force was used in the rape and the parties have been separated for three months.¹⁴

Another barrier to prosecution is "spousal privilege," a rule of evidence that provides that one spouse cannot be forced to testify against the other. The rationale for the rule relates to the state's traditional reluctance to undermine the "sanctity" of the marital relationship. Although the rationale would seem to have little applicability when one spouse has been charged with injuring the other, until recently the only exception to the privilege was a charge involving abuse of a child under age 18. Recent legislation created another narrow exception when one spouse is accused of assault and battery against the other and the victim invoked spousal privilege in a previous prosecution for the same crime within the previous year.¹⁵ Given the power and control a batterer exerts over the victim, it is unlikely that women freely make the decision to invoke the privilege. In any event, when a woman is the only witness to her husband's abuse, her decision to invoke the privilege, however made, often makes criminal prosecution difficult or impossible.

In addition to these barriers to criminal prosecution that are built into current law, the effectiveness of criminal prosecution depends on the policies and practices of prosecution offices around the state. Some state's attorneys offices in Maryland have developed specialized units and innovative policies to promote prosecution of batterers and provide protection and support for victims throughout the process. Some prosecutors and judges, however, may still view domestic violence as a private family matter and give it a lower priority than stranger-to-stranger assaults. Such attitudes affect the decision to prosecute, the level of bail, and sentencing. Even in Baltimore City, where there is a specialized unit for prosecution of

domestic violence offenses and judges receive training in the dynamics of domestic violence, 57% of the cases handled by the state's attorney's Domestic Violence Unit in 1993 were dismissed or put in the inactive docket.¹⁶ In the relatively few domestic violence cases in which convictions were obtained, very few offenders received jail time.¹⁶ Thus, given the limitations of criminal prosecution, it is particularly important to advise domestic violence victims of their other legal remedies.

Civil protection orders. Civil protection orders, in which the court can order an abuser to vacate the family home, provide temporary protection from abuse for victims and/or their children. The procedure is relatively simple and the vast majority of victims who seek such relief go to court without a lawyer. The victim goes to the local district or circuit court to obtain an "ex parte" order (so named because the alleged abuser is not present in court when it is issued), fills out a form (petition) provided by the clerk's office, and then tells her "story" to a judge. To be eligible for relief under the statute, the victim first must demonstrate that she is related by blood or marriage to the abuser, or has a child in common with him, or is a former spouse, or has cohabited with him for at least 90 days during the last year.¹⁷ Next, she must have suffered abuse as defined by the statute (serious physical injury or the threat of such injury; battery; attempted or completed rape or sexual offense; or false imprisonment). If the victim is covered by the statute, the judge can issue an order that, among other things, requires the abuser to refrain from further abuse and to vacate the family home. The order also can grant the victim custody of minor children.

The order must be delivered to the abuser by a law enforcement officer. It is in effect for approximately seven days until a hearing is held, which the abuser may attend. At the second hearing, the victim can get a "protective order" that will remain in effect up to 200 days. Again, the judge can grant custody of minor children and order the abuser to vacate the family home and refrain from abuse. In addition, the judge can order the abuser to pay support for children or a spouse and to obtain counselling for batterers, drug abuse, or alcoholism.

Properly drafted protection orders are effective in eliminating or reducing domestic abuse.¹⁸ They can provide victims the "safe place" they need to make long-term decisions to protect themselves and their children.

Physician's legal responsibilities: reporting requirements

Child abuse. Notwithstanding any law on privileged communications, any health care practitioner acting in a professional capacity who has reason to believe that a child has been

subjected to abuse must notify the local department of social services or the appropriate law enforcement agency.¹⁹ A physician with reason to believe a child has been subjected to neglect must notify the local department of social services. If the professional is acting as a staff member of an institution (e.g., hospital), the head or designated head of the institution must be notified immediately and given all the information required by the statute.

Vulnerable adult. A "vulnerable adult" is one who lacks the physical or mental capacity to provide for his or her daily needs. Notwithstanding any law on privileged communications, any health care practitioner who contacts, examines, attends, or treats a vulnerable adult and has reason to believe that the person has been subjected to abuse, neglect, self-neglect, or exploitation must notify the local social services department. If the health care practitioner is acting as a staff member of a hospital or public health agency, the head or designated head of the institution must be notified immediately and given all the information required by the statute.²⁰

Institutionalized person. A person who believes an individual in a facility has been abused (physically injured or sexually abused in any way) must promptly give as much information as possible (orally or in writing) to the appropriate law enforcement agency.²⁰

Developmentally disabled person. A person who believes an individual with developmental disability has been abused (physical injury that is inflicted willfully with gross recklessness, inhumane treatment, or sexual abuse) must promptly report the abuse to the executive director or administrative head of the institution, who then must make an oral or written report to the appropriate law enforcement agency.²⁰

Spousal abuse. In Maryland, there is no requirement to report domestic violence. The victim is responsible for reporting the abuse to the proper authorities. Such laws do exist, however, in other states (e.g., Kentucky, California). Although it can be argued that mandatory reporting of spousal abuse may promote patient safety or even save lives, it also may put victims at risk of retaliatory harm by their abusers. Given the uncertainties surrounding criminal prosecution discussed above, women may be put at such risk without any real promise of protection. Furthermore, because many women feel ambivalent about identifying themselves as victims and subjecting their partners to official reprimand, mandatory reporting could discourage women from receiving needed medical attention unless the legal system in Maryland—both the statutory framework and those who implement it—becomes more responsive to victims.

Recent legislation requires the Maryland Department of Health and Mental Hygiene to develop and implement pilot domestic violence protocols in three hospitals in the state.²¹

Perhaps these programs, along with the efforts of other hospitals and committed health care practitioners around the state, will provide the model for effective intervention for victims of domestic violence.

References

1. U.S. Department of Justice. *Report to the Nation on Crime and Justice: The Data*. Bureau of Justice Statistics; 1983.
2. Browne A. Violence against women: relevance for medical practitioners. *JAMA* 1992;267:3184-3189.
3. Stark E, Flitcraft A. Violence among intimates: an epidemiological view. In: Van Hasselt VB, Morrison RL, Bellack AS, Hersen M, ed. *Handbook of Family Violence*. New York: Plenum Press; 1987.
4. Langan PA, Innes CA. *Preventing Domestic Violence Against Women*. Bureau of Justice Statistics; 1986.
5. *Wife Abuse in the Medical Setting: An Introduction for Health Personnel*. Washington, DC: Office of Domestic Violence; 1981.
6. Domestic Violence Act of 1994.
7. Md. Ann. Code, Art. 27-594B, as amended by the Domestic Violence Act of 1994.
8. 2 *West's Maryland Law Encyclopedia* 537. West; 1960.
9. Gilbert, RP. *Maryland Tort Handbook*. § 3.1. 2nd ed. 1992.
10. 11 *West's Maryland Law Encyclopedia* 75. West; 1961.
11. Md. Ann. Code, Art. 27 §35A (1992).
12. Md. Ann. Code, Art. 27 §121A (1992).
13. Md. Ann. Code, Art. 27 §121B (1993).
14. Md. Ann. Code, Art. 27 §462 (1992) as amended by the Domestic Violence Act of 1994.
15. Md. Ann. Code, Art. 27 §462 (1992) as amended by the Domestic Violence Act of 1994.
16. The Second Baltimore City Domestic Violence Summit, May 1993.
17. Md. Ann. Code, Fam. Law 4-504 eg seq (1992) as amended by the Domestic Violence Act of 1994.
18. Finn F, Colson S. National Institute of Justice, Civil Protection Orders: Legislation, Current Court Practice, and Enforcement 1990;4.
19. Md. Ann. Code, Fam. Law §5-704.
20. Md. Ann. Code, §14-302.
21. Domestic Violence Medical Response Act of 1994. ■

The Domestic Violence Medical Response Act

Joan Stine, M.H.S., M.S., CHES

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In recognition that domestic violence is one of the major public health problems in American society today and that effective hospital emergency response is a critical factor in addressing the problem, the 1994 Maryland General Assembly enacted into law House Bill 367—the Domestic Violence Medical Response Act. This important piece of legislation requires that the Department of Health and Mental Hygiene in consultation with the Maryland Hospital Association and the Medical and Chirurgical Faculty of Maryland develop and implement a pilot domestic violence protocol program in Maryland. These three designated agencies will solicit applications from interested hospitals in the state and, to the extent possible, will select three hospitals representing an urban, suburban, and rural area.

The legislation recognized the already significant contribution of Med Chi, which has joined with the Maryland Alliance Against Family Violence to create the Maryland Physicians' Campaign Against Family Violence. The Campaign has worked with hospitals and local medical societies to train local health care practitioners to recognize, treat, and refer the victims of family violence.

According to Delegate Joan Pitkin, Prince George's County, the bill's major sponsor, the legislation will put in place a system of medical advocacy for victims of domestic violence. Delegate Pitkin, along with other bill sponsors and supporters, recognized and supported the need to develop a coordinated, on-site system to provide services for victims of domestic violence. The legislation requires that selected hospitals will use standardized protocols and training programs designed to improve emergency room response for victims of domestic violence.

In addition, the legislation requires the defining of roles and responsibilities of all who interact with and treat victims of domestic violence. Hospital staff will receive in-service training and education about the prevalence of family violence in Maryland and the nation.

Supporters of the bill want to ensure that hospital staff develop increased skills and competence in recognizing the physical and mental signs of family violence in such a manner that victims will feel trust and confidence in their providers.

The pilot project promotes appropriate referral to agencies and groups in the community that can provide follow-up services and assistance. The law further provides that the Maryland Department of Health and Mental Hygiene monitor the success of this pilot program in providing care to victims of domestic violence. ■

Sponsors and supporters of House Bill 367

| | |
|----------------------------------|-----------------------------------|
| Delegate Joan B. Pitkin | Delegate John D. Jefferies |
| House Speaker | Delegate Christine M. Jones |
| Casper R. Taylor, Jr. | Delegate A. Wade Kach |
| Secretary of Health | Delegate Delores G. Kelley |
| Nelson J. Sabatini | Delegate Ruth M. Kirk |
| Delegate Leon Albin | Delegate Martha S. Klima |
| Delegate Kumar P. Barve | Delegate Nancy K. Kopp |
| Delegate Joanne C. Benson | Delegate Carolyn J. Krysiak |
| Delegate Rosa Lee Blumenthal | Delegate Salima Siler Marriott |
| Delegate Rose Mary Hatem Bonsack | Delegate Charles A. McClenahan |
| Delegate Joan Cadden | Delegate Brian K. McHale |
| Delegate Mary A. Conroy | Delegate Maggie McIntosh |
| Delegate Elijah E. Cummings | Delegate Pauline H. Menes |
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| Delegate Donald B. Elliott | Delegate Marsha G. Perry |
| Delegate Nathaniel Exum | Delegate Carol Stoker Petzold |
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| Delegate James W. Hubbard | Delegate Leonard H. Teitelbaum |
| Delegate Brenda B. Hughes | Delegate Virginia M. Thomas |
| Delegate John Adams Hurson | Delegate David M. Valderrama |
| Delegate Leslie Hutchinson | |

Legislative advances gained by passage of The Domestic Violence Act of 1994

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Domestic violence is a serious and often deadly problem that affects Maryland citizens in epidemic proportions. Since its incorporation in 1980, the statewide coalition Maryland Network Against Domestic Violence (MNADV) has addressed this problem on many fronts. In 1994, the MNADV spearheaded efforts to create and pass comprehensive legislation that would include many elements lacking in our laws affecting victims of domestic violence. Entitled The Domestic Violence Act of 1994, the bill was the product of partnerships between the MNADV and several key legislative leaders in Annapolis. It was included on the 1994 Legislative Agenda for Maryland Women, which was endorsed by a coalition of 69 organizational supporters and 237 individual supporters. By the close of the Maryland General Assembly session on April 11, 1994, six of the bill's nine original elements survived intact or with partial improvements. **Table I** summarizes the results of The Domestic Violence Act of 1994. Each element is detailed below to emphasize its meaning and impact on victims and the agencies and individuals who interact with victims. The changes took effect October 1, 1994.

Passed provisions

Notice to victims of available services. This provision requires that when law enforcement officers respond to a request for assistance, they must give domestic violence victims written notice of services available in the community, including shelter, counseling, and their legal options in Maryland's civil and criminal courts. The simple act of informing victims about available help will greatly facilitate bringing safety to the threatened family. It is also expected that helping families gain access to service providers will ultimately reduce the number of calls to police for emergency help. Several Maryland jurisdictions, including Anne Arundel, Baltimore, Frederick, and Prince George's counties, used the technique before it was legislated and reported good results.

Table 1. Elements of The Domestic Violence Act of 1994, Effective October 1, 1994

| New Law | Old Law |
|--|--|
| When responding to a request for assistance, law enforcement officers shall give domestic violence victims written notice of services available in the community, including shelter, counseling and their legal options available in Maryland's Civil and Criminal Courts. | No provision for victim notice existed. |
| Law enforcement officers may now arrest without a warrant if they have probable cause to believe a violation of a Civil Protection Order has occurred. | A law enforcement officer may arrest if a violation of a Civil Protection Order is observed by the officer. |
| A police officer may arrest a person without a warrant if: 1. the officer has probable cause to believe that the person battered the spouse or cohabitant, and; 2. a report to the police was made within 12 hours of the incident | A report to the police needed to have been made within 2 hours of the incident. This 2 hour limit was argued to be unrealistic because victims could easily be detained at a hospital seeking medical care for injuries longer than the 2 hour requirement. |
| Expanded the state's definition of victims to "victim of domestic violence." This change allows unmarried victims of domestic violence who cohabit with or formally cohabitated with the batterer to receive state funded services. This element also changes the crime of "spousal assault" to the crime of "domestic abuse." | The state's former definition only included battered spouses which prohibited unmarrieds from receiving state funded services. Requests for police assistance in family violence cases previously referred only to spousal assaults. |
| Regarding marital rape, among other requirements, the victim needs to have been separated for 3 months to prosecute. | The victim had to be separated 6 months to prosecute. |
| The state can now compel a spouse-victim to testify against the spouse-batterer on a charge of assault and battery if: 1. the charge is the second offense within the same year and; 2. the spouse-victim refused to testify when sworn in at a previous trial invoking "spousal privilege." | There was no provision for compelling a spouse-victim to testify against the spouse-batterer when the spouse is the victim. However, the spouse could be compelled to testify against the marital partner when the abuse of a child under 18 is the alleged crime. |
| Mental Injury has been added to physical injury in the child abuse laws. Maryland was the only state in the union that did not recognize mental injury to children until this year. Mental injury relates to injury done to a child by a parent, caretaker, or other family member, under circumstances that indicate that the child's health or welfare is harmed or is at substantial risk of being harmed. Specifically, mental injury means the observable, identifiable and substantial impairment of a child's mental or psychological ability to function. The mental injury needs to be verified by 2 of the following: 1. licensed physician 2. licensed psychologist 3. licensed social worker Finally, the new law removed the exemption of non-medical religious remedial care and treatment from the definition of "abuse" and "neglect." | No provision recognizing mental injury to children existed. |

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Definition of victims of domestic violence. The Annotated Code of Maryland formerly defined victims of domestic violence in terms of their marital status. Thus, only married

individuals could be considered victims, and funding awarded by the state to domestic violence service programs was earmarked for married victims only. Not only did the defini-

tion create bookkeeping problems for program administrators, the exclusion of nonmarried victims dismissed from the state's recognition an entire segment of victims who often have children in common with the batterer and are in great danger. The Domestic Violence Act of 1994 replaced the term *battered spouse* with *victim of domestic violence*, thus allowing nonmarried victims to receive state help.

Child abuse: mental injury. Maryland formerly held the dubious distinction of being the only state in the country that did not include mental injury as a form of abuse in its child abuse laws. The omission represented a serious lack of appreciation that mental injury does exist and can be extremely damaging to children. In addition, because Maryland did not comply with the federal directive to include mental injury in its law, the state lost hundreds of thousands of federal dollars annually.

The Domestic Violence Act of 1994 added mental injury to Maryland's child abuse laws. Mental injury is defined as the observable and identifiable impairment of a child's mental or psychological ability to function, resulting from injury done by a parent, caretaker, or other family member. The law requires professional assessment of a child if mental injury is suspected. It also requires that the mental injury be verified by two of the following professionals: licensed physician, licensed psychologist, licensed social worker. Finally, the new law removes the exemption of nonmedical religious remedial care and treatment from the definition of "abuse" and "neglect."

As a result of this provision, child protective service workers may experience an increase in demands for investigation and service requests based on more referrals. Physicians and mental health professionals will need to familiarize themselves with mental injury and its varying expressions in order to diagnose the condition. They also may need to prepare for court appearances to describe the mental injury, support their findings, and ultimately, play a key role in bringing protection to these children.

Partially passed provisions

Mandatory arrest for violations of civil orders of protection. Victims of domestic violence often turn to the judicial system for protection from abusers. Many times, the relief takes the form of a civil order of protection. Such orders offer several kinds of help, including orders to vacate the family home; "stay away" provisions that cover schools and places of employment; custody and visitation awards; counseling provisions; some financial help in the form of emergency family maintenance; and overarching orders to refrain from violence. Many abusers,

however, fail to obey these orders. Maryland law stated that officers *may* arrest if a violation was *observed* (emphasis added).

The Domestic Violence Act of 1994 proposed that law enforcement officers be required to arrest if there is probable cause to believe violation of a civil order of protection occurred. Although the General Assembly did not pass the mandatory arrest provision, it did reduce the level of evidence needed to arrest: from observing the violation to having probable cause to believe the violation occurred.

The improvement will strengthen the ability of officers to enforce protection orders and greatly discourage violations of orders, which are common. A frequent occurrence is the batterer's coming to the family home despite a court-issued "stay away" order. The victim calls police, but by the time an officer arrives, the batterer has fled. Under the former law, the officer could not intervene effectively. Now, the officer can issue an arrest warrant when there is probable cause to believe a violation was committed.

The former law also required victims to file a police report within two hours of the assault. For a variety of reasons, the unrealistically short time allowed often prohibited victims from filing the report: some victims would be in a hospital emergency room seeking medical treatment or unable to find child care while they went to the police station; others, in a crisis state of mind so soon after being beaten, would be unable to initiate any action very well. The bill proposed that the length of time allowed to file a police report be extended from two hours to 48 hours. The General Assembly approved extending the time limit to 12 hours.

Marital rape. In 1989, the first law recognizing that rape and other sexual offenses occur within marriages was passed in Maryland. Unlike nonmarried sexual assault victims, however, married victims had to meet several special provisions before prosecution of the crime could be considered. For example, written separation agreements were needed in some cases, and a minimum separation time of six months was required in others. The Domestic Violence Act of 1994 proposed identical prosecution of perpetrators of sexual violence, regardless of their marital status. Although the General Assembly did not eliminate all the differences, it did reduce the time of separation needed from six months to three months.

Spousal privilege: compelling testimony. Maryland has several laws, based on English common law, that purport to protect the sanctity of marriage by allowing marital partners to refuse to testify against each other. In Maryland, a judge may not compel one spouse to testify against the other, even when one spouse is the victim of a crime at the hands of the other.

This legal privilege, however, may have serious consequences for victims of domestic violence. A common example occurs when a wife who is beaten files criminal charges against her husband. The husband may try to pressure his wife not to testify by threatening, begging, cajoling, or "sweet talking" her. The wife is placed in the extremely uncomfortable position of having to decide whether to testify. All too often, she succumbs to the pressure and does not follow through with prosecution. Before The Domestic Violence Act of 1994, a spouse-victim could not be compelled to testify against a spouse-batterer in court.

The Domestic Violence Act of 1994 proposed eliminating the spousal privilege provision and allowing state's attorneys and judges to handle domestic violence battery cases like any other assault. A modified version of this element was passed. Now, the state can compel a spouse-victim to testify against the spouse-batterer on a charge of assault and battery if the charge is the second offense within the same year and the spouse-victim, invoking "spousal privilege," refused to testify when sworn in at a previous trial. Because there is evidence that prosecution of these cases decreases future violence, lifting the burden of deciding to testify from the victim may result in more prosecutions and, ultimately, an end to the cycle of violence.

Unpassed provisions

Mandatory police reports. This element would have required law enforcement officers to make a written report for all domestic violence calls. In 1992, 16,834 spousal assault reports were written by Maryland law enforcement officers.¹ Although this number is staggering, experts estimate it represents only 10% to 20% of the calls law enforcement officers actually handled. The MNADV believes mandatory written reports would provide a more accurate picture of the prevalence of domestic violence and would facilitate prosecution of cases brought into the court system.

Spousal privilege: confidential communications. Maryland law currently provides that conversations between married people are privileged and cannot be used in court as evidence against a spouse who is on trial. The MNADV supported elimination of this privilege based on a recent case in which a husband was convicted by a jury of battery and two counts of second-degree sexual offense. He was found to have engaged in nonconsensual anal intercourse with his wife while placing a large dildo in her vagina. He had telephoned her after the episode, apologized to her, and expressed his desire to resume their marriage. During the trial, the wife testified about this conversation, using it as supporting evidence that the crime occurred. The conviction

was appealed in Maryland's Court of Appeals, which overturned the guilty verdict on the grounds that the dialogue between husband and wife was privileged and could not be used as evidence, even when the spouse is the victim.

Child abuse testimony: fair trial. This provision would have allowed defendants charged with serious crimes, including murder and maiming, to introduce evidence of the "battered child syndrome" in their own defense. "Battered child syndrome" refers to the psychological condition of a person suffering from repeated physical, psychological, or sexual abuse by a parent or other person who has or had permanent care or custody of the victim. Such a provision would allow judges to have access to this information during a trial. A similar, existing Maryland law for "battered spouse syndrome" allows a history of spouse abuse to be heard in court in the defense of one spouse accused of committing a serious crime against the other.

The Future

The Domestic Violence Act of 1994 is a tribute to what can be accomplished when concerned organizations and individuals work together to improve Maryland's response to victims of domestic violence. Nevertheless, a key element—mandatory arrest for violations of civil orders of protection—did not pass. Many batterers refuse to abide by such orders, and as the law stands, officers *may* arrest a violator, but are not *required* to do so. As part of its 1995 legislative agenda, the MNADV will emphasize mandatory arrest for violators of existing civil orders of protection.

Reference

1. Maryland State Police. Crime in Maryland—1992. *Maryland Uniform Crime Reports* 1993:44. ■

A copy of the complete MNADV 1995 legislative agenda may be obtained by calling 1-301-942-0900.

Physicians and domestic violence programs: partners in change

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Physicians play a vital role in identifying and providing referrals to battered women who seek medical help. Once referrals have been provided, the physician's responsibility to the patient has been met, but for the battered woman the healing process has just begun. This article describes the assessment and services provided to the battered woman once she leaves the physician's presence. It also describes the healing process in terms of Maslow's hierarchy of needs (Table 1) and how the physician's intervention can be the first of many provided to the domestic violence victim.

Case history

Dr. A, working the overnight shift in the emergency room of the local hospital, has just treated a woman whom he has identified as being abused. The police brought her to the emergency room. Her partner was taken into custody, but it is uncertain how long he will be held. The woman has a two-year-old child and an infant with her. Extremely concerned about her safety, the physician calls the Domestic Violence Center and wants to know what services it can provide. The helpline volunteer asks to speak with the woman and determines that it is not safe for her to return to her home tonight. The volunteer tells the victim that she will contact shelter staff and that someone will call her back. The volunteer then explains this to the physician and

Table 1. Maslow's needs hierarchy

| | |
|----------------|--|
| Level 1: | physiological needs (food, water, etc.) |
| Level 2: | safety needs (security, stability) |
| Level 3: | love and belonging (affiliation, acceptance) |
| Level 4: | esteem (success, status) |
| Level 5: | self-actualization |

recommends that a hospital staff member (physician, nurse, social worker) review safety planning with the patient. Shelter personnel call the woman and assess her situation; they jointly decide that immediate shelter is in her best interest. Shelter personnel arrive at the hospital and take the woman and her children to a place of safety and support.

Making referrals

How does the physician know when and to what local agencies to make referrals? With cases coming into the emergency room or the physician's office, medical personnel should recognize the physical and emotional signs and symptoms that assist in making the diagnosis of domestic violence:

- ❑ patterns of abuse;
- ❑ stress-induced medical illness;
- ❑ problems/injuries during pregnancy;
- ❑ psychiatric signs;
- ❑ partner and patient behavioral signs.

Once the diagnosis is made, the referral process should begin. Referral numbers for local agencies should be readily available, and staff members should be able to give the victim information about local programs, including briefly describing the various services offered. The physician or a staff member should make the initial call for the patient or let her call in privacy from an office.

Caseworker's assessment

Once a referral has been made, the domestic violence professional assesses the client's circumstances and needs. Although options are discussed, responsibility for choices remains with the client. Only the client can know what is in her best interest. If the counselor and client agree that she is not safe at home, then shelter is discussed. The client is told that she would be entering a program governed by the principles of safety and confidentiality. It must be determined whether the client is capable of caring for herself and her children given a safe and supportive environment. Each shelter program in Maryland has developed its own assessment tools and criteria for eligibility. Once the client and the counselor decide that shelter is the best option, arrangements are made for her to enter the shelter system.

System at the Domestic Violence Center of Howard County

The shelter system established by the Domestic Violence Center of Howard County, Inc., (DVC) is based on the psychological theory of Abraham Maslow. Maslow's needs hierarchy¹⁻³ fits well with the healing stages a battered woman must go through to fully establish herself outside of an abusive

relationship. The DVC helps the client begin the journey of self-discovery and self-actualization in its emergency safehouse.

Clients enter the safehouse in a state of crisis and often are unable to make even a small move toward independence, which fits Maslow's model at the first level (seeking to meet the most basic physiological needs, such as food or air). By leaving the abuser, clients have taken the first step toward meeting Maslow's second level: safety. The true impact of that decision, however, does not manifest itself until a few days into the program, when clients and their children feel safe for perhaps the first time in their lives. According to Maslow's theory, clients cannot handle any information other than that which answers the basic needs of food and safe shelter. Other than receiving emergency crisis intervention services, clients are not ready to make any major steps toward independence. They can stay in the safehouse facility for up to 21 days.

The goal of DVC's model is to immerse clients in a safe, healthy, and supportive environment that is geared toward self-determination and building a sense of community. Clients in the second, third, and fourth months of their stay with the program are ready to work on Maslow's third level: the issue of belonging. Belonging is helpful in understanding why domestic violence victims return to their abusers once they begin to feel safe. Immersion in a community based on nonviolence helps retain clients in the program and stop the revolving door that domestic violence residential programs experience with their clients. Supportive services help increase skill and education levels so clients can leave the first stage transitional facility after approximately five months and move into second stage transitional housing.

When clients enter second stage transitional housing, they have moved to Maslow's fourth level: self-respect and self-worth. The supportive services program helps to facilitate this growth process, which is ongoing and cannot be completed while in the residential program. Case management helps clients make a smoother transition from a residential program to independent living. Supportive services include but are not limited to case management, individual counseling, group counseling, guided play therapy, crisis intervention counseling, legal services, emergency funding for personal necessities, transportation, referral/advocacy to other supportive resources, and food and shelter in a safe, confidential environment.

The total residential stay is a maximum of 24 months (average, one year). Shorter terms of stay depend on a client's cooperation with transitional housing rules and regulations, coordination of services, and resolution of her homelessness. Progress is evaluated weekly and monthly on the individualized client action plan, which has specific, measurable, goal-oriented activities outlined for each week.

During the transitional housing phase, clients are expected to become more independent and to realize some of the goals of the action plan. In order for a battered woman to experience some new feelings of empowerment and independence, her dependency on supportive services should decrease during this time in preparation for successful resolution of the family's homeless status. The program has three general goals.

Goal 1: residential stability

The success of DVC supportive services is measured by the number of clients who live independently and maintain a nonviolent environment during a six-month follow-up period. DVC estimates, based on statistics generated during the past 16 years of service, that 50% of its clients in emergency shelter graduate to the first stage transitional housing; 50% of those clients move to second stage transitional housing; and 50% of the latter move into independent living with a Section 8 certificate while 50% move into nonsubsidized housing.

Most DVC clients leave the program unsuccessfully because of the lack of supportive services during the transitional process. In terms of Maslow's model, the transition phase is the most crucial; when basic needs (food, shelter, safety) are met, the domestic violence victim begins to crave the human connection. During this phase, a program must foster the client's connection with other clients and with agency personnel. If the program does not, clients may be overwhelmed by feelings of abandonment and loneliness. Thus, the supportive services component of this model fills the void left by the absent abuser (abusive relationships are not all brutality; there are periods of closeness and happiness). The success of the model is therefore evaluated on the attrition rate of clients based on exit interviews with all clients who leave the program.

Goal 2: independence

The overall objective of the DVC model is to enable clients to increase the skills necessary for independent living. One way DVC accomplishes this goal is through a cooperative effort with the Howard County Community College project "Mentoring, Education, Employment, and Training" (Project MEET). On entering the program, clients meet a case manager who evaluates their needs and refers them to Project MEET for further evaluation. Clients then begin an individualized training program. Weekly progress is measured by attendance and completion of training.

By connecting the client with the community and fostering a sense of self and how the self fits into the whole, the program again follows Maslow's model. Educational and life-skills training begins to fulfill the client's need for belonging. Battered women enter the DVC program with shattered self-

esteem and no resources. As they take small steps toward self-reliance, each success is a building block that improves self-esteem.

Goal 3: self-determination

The entire model is based on the premise that the battered woman is in charge of her own destiny. She is the expert on her situation, what brought her to the program, and what support and guidance she needs to resolve her family's homelessness. The DVC philosophy is that the client knows best: staff members do not impose their beliefs or judgments on clients. Each action plan goal is determined by the client with input and options given by the DVC staff. The cycle of domestic violence creates a dysfunctional behavioral pattern of learned helplessness that can be broken by giving clients complete self-determination. Self-determination blossoms in an atmosphere of freedom and safety. DVC measures movement toward self-determination by the number of decisions clients make without input from counselors and by the level of competency displayed in interpersonal relationships.

The expected results of a model based on Maslow's needs hierarchy are that structured, gradual increases in freedom will allow clients to experience the empowerment of independent living. According to Maslow, each level of the needs hierarchy builds on the prior level. Thus, if at any point in the program, the woman's safety is jeopardized, all work on belonging, connectedness, and self-esteem is temporarily suspended. Each stage of the model builds on the previous stage and is necessary for the success of the entire program. Clients can only address higher needs when lower needs are met: no phase can stand alone.

References

1. Maslow AH. *Motivation and Personality*. New York: Harper & Row; 1954.
2. Maslow AH. *Toward a Psychology of Being*. 2nd ed. Princeton, NJ: Van Nostrand; 1968.
3. Maslow, AH. *The Farther Reaches of Human Nature*. New York: Viking; 1971. ■

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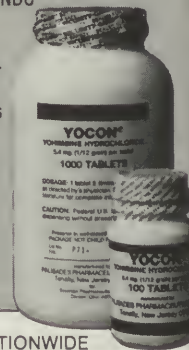
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Developing the Maryland Physicians' Campaign Against Family Violence.

An interview with Med Chi's chief operating officer, Roseanne Matricciani

Ruth M. Seaby, M.A.S.

Ms. Seaby is the director of communications of the Medical and Chirurgical Faculty of Maryland.

On June 20, 1994, MedChi's chief operating officer, Roseanne Matricciani, R.N., J.D., along with Governor William Donald Schaefer, Health and Mental Hygiene Secretary Nelson Sabatini, Time Group President Constance Caplan, and Whiteford, Taylor and Preston attorney Steven Bers, Esq., were honored by the House of Ruth for the continued support and enormous generosity they have shown toward the victims of domestic violence throughout the state. The recognition of Ms. Matricciani came because of her work with the Maryland Physicians' Campaign Against Family Violence. After she received this award, Ms. Matricciani met with Med Chi's communications director, Ruth Seaby, to discuss the Maryland Physicians' Campaign from its inception to the present.

“**M**ed Chi began working on The Maryland Physicians' Campaign in early 1993, after members of the Maryland Alliance Against Family Violence (MAAFV), an organization composed of 24 private and public agencies, approached us about working with them on a family violence awareness campaign for the medical community,” says Ms. Matricciani. Then-president Joseph Snyder, M.D., liked the idea. “He knew the AMA had already begun encouraging physicians to become more aware of family violence issues,” she continues, “and saw this partnership with MAAFV as a tremendous opportunity to work with resources available in Maryland and develop a program that tied in with the AMA's national campaign.”

Task Force on Family Violence

Recognizing that family violence is a public health issue and the campaign would need publicity, Dr. Snyder appointed Martin Wasserman, M.D., J.D., chairperson of the Committee on Public Health, and Hiroshi Nakazawa, M.D., chairperson of the Public Relations Committee, to co-chair the newly formed Task Force on Family Violence and Ms. Matricciani to



Governor Schaefer presents Ms. Matricciani with an award of appreciation from the House of Ruth.

serve on the task force. The task force was charged with developing a statewide training program for physicians about family violence and Med Chi designated \$25,000 for start-up funds. The Department of Health and Mental Hygiene and the Department of Human Resources also provided funding for the campaign.

During the summer of 1993, the founding members of the task force—Drs. Wasserman and Nakazawa; Ms. Matricciani; Joanne Tulonen, M.P.A., executive director of the Maryland Alliance Against Family Violence; and Jann Jackson, M.S., associate director of the House of Ruth—discussed the best way to organize this campaign. Similar campaigns directed by the AMA and other medical societies had developed separate programs and materials addressing different types of family violence, such as domestic violence or child abuse. The task force determined that the Maryland campaign should consist of three phases: domestic violence, child abuse, and elder abuse. Each phase of the campaign would be designed to increase physician and public awareness about these problems.

“Working with MAAFV gave us access to specialists in each of these areas,” says Ms. Matricciani. “We determined that having a multidisciplinary task force, one composed of physicians, nurses, social workers, legal professionals, and family

violence advocates, would enable us to develop the most successful program. So we began to expand the task force by recruiting members from various organizations, including the Department of Health and Mental Hygiene, medical specialty societies, and nursing associations. We knew that we were asking task force members for an extensive time commitment, but, we generally received positive responses to our requests.” The task force currently has representatives from more than 20 medical and health-related organizations and meets on a monthly basis to continually coordinate the campaign.

Phase one

One of the first things the task force did was choose “Unlock the Silence. Trust is the Key” as the theme for the campaign.

“Although domestic violence is the leading cause of injury to women in the United States, less than 5% of domestic violence victims are identified in a medical setting,” says Ms. Matricciani. “The

theme selected by the task force addresses the silence that surrounds this issue by both the medical community and victims. Since medical professionals are often the first people to see victims of family violence, and patients generally trust their physicians, the physician-patient relationship can provide an opportunity for frank discussion.”

Ms. Matricciani notes that many abuse victims try to hide the abuse they receive because they are afraid, anxious, or embarrassed. “Talking to anyone about their situation is extremely difficult for these victims,” she says. “We wanted a theme that acknowledges how difficult it is for these victims to talk about the abuse, but at the same time, encourages them to talk about it.” Once the campaign’s theme was chosen, Med Chi’s graphics department developed a logo for the campaign’s printed materials.

For the initial phase of the campaign, the task force chose to focus on domestic violence.

“We wanted to start with domestic violence for several reasons,” says Ms. Matricciani. “Through its research, the task force learned that only limited medical information was available about how to recognize and treat domestic violence victims. The task force felt it was critical to get relevant material about domestic violence to physicians and other health care providers. Also, in 1994, the Joint Commission on

the Accreditation of Healthcare Organizations (JCAHO) mandated that hospitals provide 'education of appropriate staff about the criteria for identifying and the procedures for handling victims of abuse,' including the abuse caused by domestic violence."

Training and education

After selecting domestic violence as the first phase of the campaign, the task force formed a training subcommittee composed of Ms. Jackson, Ms. Tulonen, and Ms. Matricciani.

"The subcommittee discussed various ways to conduct the training program for physicians and other health care providers, and reviewed materials from similar programs," says Ms. Matricciani. "We particularly liked the materials developed by the Ohio State Medical Society (OSMA)."

OSMA had developed a comprehensive packet of materials that included a handbook for physicians, a tent card urging domestic violence victims to talk to their doctors, a poster for the doctor's office, and card with questions for victims. "We were very impressed with the handbook that OSMA had developed because it provided information on how to approach possible battering victims, clinical guidelines for recognizing abuse, legal considerations, and a list of domestic violence shelters throughout the state."

Based on the recommendations from the training subcommittee, the task force decided to use the OSMA materials as a model for the Maryland campaign. In addition, the task force determined that domestic violence awareness seminars for physicians and other health care providers should be a part of the campaign. "The task force wanted to extend this information to all members of the health care community and, at the same time, help the hospitals in the state comply with the JCAHO guidelines," says Ms. Matricciani.

The training subcommittee worked throughout the fall of 1993 and early 1994 to develop a physician's manual customized for Maryland. During the manual's production, the subcommittee relied on the domestic violence specialists on the task force for guidance. "These individuals helped us identify and gather critical information for the manual," says Ms. Matricciani. "I think that some of the manual's most important information is contained in the medical power and control wheel, and the advocacy wheel."

The medical power and control wheel lists behaviors by the medical community that can further victimize and endanger an abuse victim. The advocacy wheel shows how physicians and other health care providers can empower an abuse victim. "We



Ms. Matricciani shows the materials developed by the Maryland Physicians' Campaign Against Family Violence to the people attending the House of Ruth's annual meeting on June 20, 1994.

included these two models to show physicians that they can help an abuse victim simply by their reaction to the situation."

Ms. Matricciani also worked closely with Med Chi's continuing medical education department so that physicians could receive CME credits for reviewing the manual and accurately completing a CME questionnaire.

Upon its completion in May, the manual and CME questionnaire, a tent card, and a victim's question card were mailed to all Med Chi members. "The overall response from the medical community about the manual has been very positive," remarks Ms. Matricciani. To date, approximately 200 physicians have completed the CME form that accompanied the manual. In addition, the manual has generated interest and gained recognition for Med Chi outside the medical profession. "We have sold manuals to members of the legal and social services community," notes Ms. Matricciani.

As an adjunct to the Maryland Physicians' Campaign, MAAFV received a \$35,000 grant from the Department of Health and Human Services for a public education campaign. As part of this grant, a victim's brochure was developed that addresses the impact violence has on a victim's health. Med Chi's graphics department helped with the brochure design and layout so that it coordinated with other campaign materials. The brochure has been published in English and will also be published in Spanish and Korean. "Spanish and Korean were chosen by MAAFV because there is a large percentage of

people who speak these languages in Maryland," says Ms. Matricciani. A brochure targeted to African Americans, as well as a nurses' manual and a clergy information packet, will also be produced from the grant funding.

Domestic violence awareness seminar

As soon as the physician's manual was completed, the training subcommittee turned its full attention to the second phase of the training program—conducting domestic violence awareness seminars throughout Maryland. To ensure that the seminars would be consistent, the task force contracted with Carol J. Scott, M.D., M.S.Ed., F.A.C.E.P., to develop a training program for the facilitators who would conduct the seminars. Dr. Scott and the subcommittee compiled a facilitator's manual and a set of slides for the facilitators to use during their presentations. Full-day facilitator training seminars were held at Med Chi on May 20 and 21, 1994.

"Eighty-nine people, including physicians, nurses, lawyers, and domestic violence advocates attended these two facilitator training sessions. We had representatives from every part of the state," says Ms. Matricciani.

Trained facilitators began conducting domestic violence awareness seminars in hospitals during June. "Taking this training directly to health care providers has been very beneficial for several reasons," says Ms. Matricciani. "It gives the professionals attending the seminar a chance to ask questions and get clarification on different issues. In addition, we usually have someone from one of the domestic violence programs in the community there to discuss the services their programs offer and meet the physicians."

Thus far, seminars have been held at eleven hospitals and an HMO, and have consistently received outstanding evaluations from participants. Seminars will continue at hospitals, HMOs, and component societies throughout the year. As the training continues, the task force will begin developing materials for the campaign's next segment on child abuse. Med Chi also has applied for a CDC grant which, if awarded, will be used to address violence against women as part of a community-based response.

Positive effects

In addition to its benefits to the medical community, the campaign has had a positive impact on domestic violence victims. Ms. Matricciani notes that she has spoken to former victims who have seen the domestic violence tent card or other materials in their physician's office. Many of these victims say that if they had seen these materials while they were in an abusive relationship, they would have talked with their physician about the abuse.

"The stories have been very moving and emotional," says Ms. Matricciani, "and each story ends with a 'thank you' to the physicians of Med Chi for taking an active role against domestic violence."

Asked how she manages the duties of this campaign with her numerous other duties at Med Chi, Ms. Matricciani quickly states that she hasn't done it alone.

"The support from Med Chi through its members and its staff has been a tremendous asset to this campaign," she says. "Our members have voluntarily taken time off from their practices to conduct training sessions. They also have made cash donations that will be used to support the campaign's future endeavors. The staff helped produce all the campaign materials, coordinated the facilitators' seminars at Med Chi, scheduled training sessions at hospitals, and provided ongoing support for many of the campaign activities. These people, along with the members of the task force and the members of the training subcommittee, deserve the credit for the success of this campaign." ■

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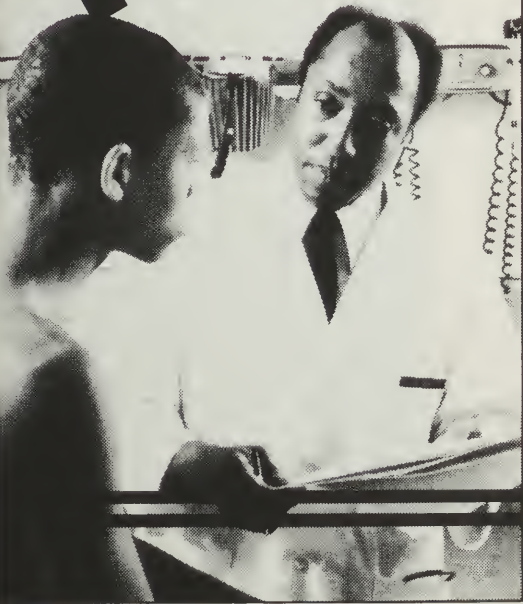
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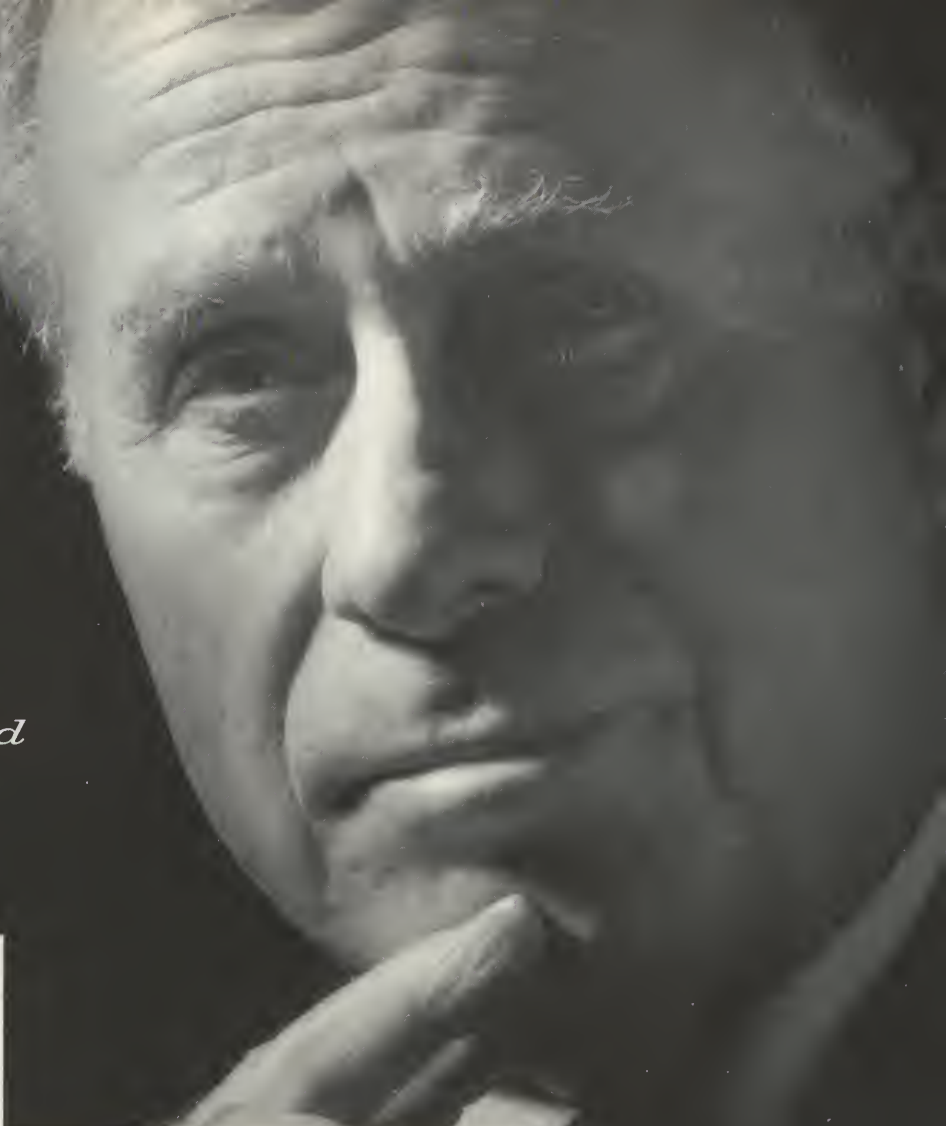
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In Memoriam

John S. Haines, M.D., a urologist who retired in 1986, died of heart failure June 5, 1994, at his home in Baltimore. Born in Philadelphia, Dr. Haines received his undergraduate degree from Washington and Lee University. Following graduate studies in Europe, he earned his medical degree at The Johns Hopkins University School of Medicine and served his internship at Hopkins hospital. He was chief of urology at the U.S. Public Health Service Hospital in San Francisco from 1943 to 1946. In addition to his private practice, Dr. Haines was a staff member at several Baltimore hospitals, including Church Home and Hospital, Greater Baltimore Medical Center, Hopkins, Mercy, and Union Memorial. A 40-year member of the Medical and Chirurgical Faculty of Maryland, he was a member of the American Medical Association, American College of Surgeons, American Urological Association, and Baltimore City Medical Society. Dr. Haines was 83.

Albert J. Himelfarb, M.D., an internist, died of stroke complications July 28, 1994, at Sinai Hospital. Born in Baltimore, Dr. Himelfarb was a 1926 graduate of City College and a 1929 graduate of The Johns Hopkins University. Upon graduation from the University of Maryland School of Medicine in 1933, he served his internship at Sinai Hospital. Dr. Himelfarb attained the rank of captain while serving in the Army during World War II. During a 50-year tenure at Sinai, he was president of the medical staff and chairperson of the medical executive committee. In 1990, the department of medicine presented him with the Distinguished Physician Award. Dr. Himelfarb was a diplomate of the American Board of Internal Medicine and a member of the Baltimore City Medical Society and the Phi Delta Epsilon medical fraternity. He was 84.

John F. Schaefer, M.D., a retired family practitioner and 1971 president of the Medical and Chirurgical Faculty of Maryland, died July 14, 1994, of congestive heart failure in his Catonsville home. Dr. Schaefer graduated from the University of Maryland School of Pharmacy in 1934 and received his medical degree in 1938 from the University of Maryland School of Medicine. During World War II, Dr. Schaefer served in the Army Medical Corps and was discharged with the rank of major in 1946. Before opening his private practice in 1952, he served as chairperson of the Disability and Disease Rating Board of the Veterans

Administration. He practiced medicine in the Catonsville and Irvington areas until his retirement in 1980. Dr. Schaefer was a member of the Board of Medical Examiners, the Baltimore City Medical Society, and the American Association of Family Practitioners. He was 81.

No additional information was available at press time for the following members:

Conrad B. Acton, M.D.
Baltimore City, July 12, 1994

Nasser H. Bahraini, M.D.
Montgomery County, July 14, 1994

Henry J. Houska, M.D.
Baltimore City, June 10, 1994

Leonid V. Maldve, M.D.
Wicomico County, June 27, 1994

Robert J. Mason, M.D.
Talbot County, June 7, 1994

Hyman S. Rubinstein, M.D.
Baltimore City, March 17, 1994

Abraham M. Schneidmuhl, M.D.
Baltimore City, July 8, 1994

John S. Shaver, M.D.
Montgomery County, August 21, 1994

Philip H. Varner, M.D.
Montgomery County, May 23, 1990 ■

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Alliance

Advocacy Can Make a Difference

During the past 16 years, Americans have become more aware of domestic violence and its effects on our society. We have increased our knowledge of the dynamics and underlying causes of this problem, and of the personal and societal variables that have an impact on the development of individuals and their subsequent behavior patterns. As a result, we have developed programs and expanded services to help the victims and perpetrators of domestic violence.

However, many critical questions remain. What is essential to any domestic violence prevention/intervention program? What range of services should be included to maximize a program's success? Under Maryland law, every domestic violence program must offer three services: shelter, counseling for the victim, and counseling for the batterer. Other valuable services that a program can offer include comprehensive children's counseling, victim advocacy, court companion services, and legal services.

Following is a brief outline of why these services are essential for the success of a domestic violence intervention/prevention program.

Shelter

Each year, six million women are assaulted. In any potentially violent situation, physical safety for the victims is imperative. In domestic violence situations, shelter is necessary to protect a woman from her abuser and give her time to heal from the physical and mental abuse she has received. Shelter is frequently needed for her children too, because children are battered in 45% to 59% of the families in which partner abuse occurs.

Leaving an abusive situation is one of the most difficult and painful decisions an abuse victim makes. By the time a woman reaches the stage where she leaves the relationship, there is usually an increased threat to her life and to the lives of her children. Fifty-two percent of all women murder victims are killed by their intimate partners, and most of these murders occur after a separation or divorce. Therefore, to avoid an escalation of violence, the community should make every effort to provide shelter for anyone who has chosen to leave an abusive relationship.

Counseling for victims

The results of physical abuse—cuts, bruises, broken bones—are often visible. The less visible emotional and

mental damage caused by abuse is just as devastating to victims. In fact, the emotional effects of abuse frequently cause the victim to remain in an abusive relationship. Abuse victims go through different phases in their relationships with their abusers. Initially, a woman may believe that the abuser will change and the abuse will stop. As the violence continues and increases, she becomes afraid, hurt, and confused. She begins to feel helpless and powerless. Her self-esteem is gone and she blames herself for the abuse. She may become suicidal (25% of all women who attempt suicide are victims of domestic violence), homicidal, or an abuser herself.

The purpose of victim counseling is to empower the victim, to remove the burden of guilt, and to help her gain control of her own life and make positive choices for herself and her family.

Counseling for the abuser

What causes someone to release rage and violence on a loved one? Possible explanations are that the behavior was learned because the perpetrator was either a victim of or a witness to abuse as a child; the perpetrator suffers from low self-esteem; the perpetrator uses violent acts to displace tension; society condones violence. Regardless of the causes, however, the abuser must recognize that he or she is committing a crime and is responsible for his or her behavior. Counseling for abusers encourages them to take responsibility for their actions and explore nonviolent ways to release emotions.

Children's counseling

Children, regardless of their age, who witness abuse are affected mentally, emotionally, and physically. Without intervention, children in early adolescence (ages 10 to 12) begin to identify with either the aggressor or the victim. Teen violence can frequently be traced back to a violent home.

Counseling services for children help break the cycle of violence that spans different generations. Through counseling, children learn that they are not responsible for the violence that has been inflicted on them and that they cannot control it. Children in these programs are also taught nonviolent ways to express emotions.

Court companion services

Battered women seek assistance from legal or law enforcement agencies an average of six times before they

enter a shelter program. Recent reports indicate that if someone is available to help a woman through the legal process, the legal intervention will be more successful in ending the violence.

Court companion services assign volunteers who are familiar with the legal system to work with abuse victims during legal proceedings. The program is very beneficial and empowering to abuse victims, who often find the legal process overwhelming.

Legal assistance

The legal system can be daunting for anyone. However, without support from the legal community, which helps a woman obtain financial support for her family and enforces legal sanctions against the abuser, many women are forced to return to an abusive situation. To help abuse victims get the legal support they need to ensure a future without violence, most state and county bar associations have lawyers who volunteer to work on these cases, give consultations, or represent victims.

Victim advocacy

Thirty years ago, the first shelter was opened in California; 22 years ago, the first hotline for abuse victims was started; 20 years ago, the first book on domestic violence was published in Great Britain. All these things happened because of advocacy on the behalf of abuse victims.

Domestic violence remains a pervasive problem in America and crosses all races, religions, ages, and socioeconomic conditions. There is an ongoing need for advocacy programs that lobby for stronger laws to protect the rights of victims or work to increase funding for services for victims.

A list of domestic violence programs and the services these programs offer can be found on pages 33-41 of Med Chi's domestic violence manual. Further information about domestic violence programs can be obtained from:

- ❑ The Maryland Network Against Domestic Violence
1-800-MD-HELPS
- ❑ The Maryland Alliance Against Family Violence
1-410-706-5472
- ❑ The Department of Human Resources
1-410-767-7477

MARCIA R. WOLF, PH.D.
Montgomery County Alliance president ■

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Summary of the NIH Consensus

NIH
Consensus
Development
Conference

February 7-9,
1994

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HELICOBACTER PYLORI IN PEPTIC ULCER DISEASE

Using a combination of antibiotics to eradicate a stomach bacterium may finally offer a cure to the 25 million Americans who at some time in their lives develop peptic ulcer disease.

According to a 14-member independent panel recently convened by the National Institute of Diabetes and Digestive and Kidney Diseases and the NIH Office of Medical Applications of Research, ulcer patients who test positive for *Helicobacter pylori* (*H. pylori*) infection should be treated for at least two weeks with a combination of bismuth and antimicrobial drugs. Dual and triple combinations of bismuth and antimicrobial drugs successfully cure *H. pylori* infection and reduce the rate of ulcer recurrence in up to 90% of ulcer patients, the panel said.

Of the several drug combinations presented during the 2½-day conference, the panel said that triple therapies, consisting of bismuth plus the antibiotics metronidazole and tetracycline, were the most effective. In some cases, resistance to metronidazole may require a substitution of amoxicillin.

The panel also identified several effective dual therapies, one of which combines amoxicillin with omeprazole, a proton-pump inhibitor. Mild side effects occur with each drug combination, but they do not normally prevent patients from completing their treatment. The panel added that standard acid-suppressing drugs should be added to the antimicrobial regimen to relieve ulcer symptoms.

Until now, the traditional treatment for peptic ulcer disease involved minimizing and suppressing acid secretion with drugs called H-2 blockers, which interfere with the release of histamine and thus reduce acid production in the stomach. The most commonly used H-2 blockers are ranitidine and cimetidine. Although H-2 blockers successfully

heal ulcers, if the patient stops taking these drugs, he or she has a 50% to 80% chance of the ulcer recurring.

But since the 1982 isolation of *H. pylori* by Australian researchers Barry Marshall and Robin Warren, many have believed that the spiral organism plays a significant causal role in peptic ulcer disease, and there has been growing interest in using antibiotics to treat ulcers.

Peptic ulcer disease, estimated to affect 4.5 million people each year in the United States, is a chronic inflammation of the stomach lining or of the duodenum. While few people die from peptic ulcer disease, it is responsible for substantial human suffering and staggering economic costs. Every year, 4 million people report missing approximately six days from work because of their ulcers. Now the panel believes that their recommended treatments will not only alter the way doctors treat ulcers, but lower health care costs and reduce human suffering.

Research indicates that *H. pylori* infects approximately 6 in 10 people in the United States by age 60, while the infection rate in developing countries is 8 in 10 people by age 5. Although uncertainty remains about how the infection is spread, person-to-person contact appears to be a significant means of transmitting the bacteria. Whether or not *H. pylori* infection can be transmitted through contaminated food and water, and how often, requires further study.

To prevent the development of bacterial resistance to antimicrobials, the panel stressed that an accurate diagnosis should be made before a patient starts any antimicrobial treatment. The panel cited several invasive and noninvasive tests that are useful in diagnosing *H. pylori* infection.

Endoscopic biopsy and cell culture are invasive tests that provide visualization and details about

Summary of the NIH Consensus con't

HELICOBACTER PYLORI IN PEPTIC ULCER DISEASE

the status of the gastric and duodenal lining. Sensitivity and specificity of these procedures range from 85% to 100%

However, the panel said that excellent diagnostic sensitivities and specificities are also produced with noninvasive tests. These include blood tests to measure the urease-secreting properties of *H. pylori*.

Although a number of highly accurate diagnostic tests are available, the panel said that some now used only in research studies will soon be available for commercial use. Despite these diagnostic tools the panel noted that there are no readily available, inexpensive, and accurate noninvasive methods to monitor eradication of *H. pylori*. Without such tools, routine monitoring for relapse, reinfection, or treatment failure cannot be recommended.

The panel also found an association between *H. pylori* infection and gastric cancer. Considered a slow and insidious disease, the incidence of gastric cancer increases with age and occurs more frequently in blacks and Hispanics than whites. Despite the fact that gastric cancer appears to occur

more frequently in some populations with higher rates of *H. pylori* infection, the panel found no conclusive evidence that treating the infection reduces cancer risk. They contend that there are factors other than *H. pylori* infection, such as geography, socioeconomic status, and ethnicity, that cause the development of gastric cancer.

Finally, the experts called for future research to determine the mechanisms and natural history of *H. pylori* infection, whether *H. pylori* eradication prevents gastric cancer, and to analyze the comprehensive cost and impact of treating versus not treating all patients who are infected with *H. pylori*. ■

Free, single copies of the complete NIH Consensus Statement on Helicobacter Pylori in Peptic Ulcer Disease may be ordered from the NIH Consensus Program Information Service, P.O. Box 2577, Kensington, MD 20891; 1-800-644-6627.

Call for Papers

The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

- Pain Management
- Patient Education
- Patients with Handicapping Conditions

Papers may be original research, literature reviews, brief reports, case histories accompanied by a brief overview/summary of the relevant literature, or well-documented opinions about future trends. Deadline for submissions is February 15, 1995.

All submissions should conform to requirements listed on the "Information for Authors" page of the *Maryland Medical Journal*. For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor, 1211 Cathedral Street, Baltimore, MD 21201; 410-539-0872 or 1-800-492-1056; FAX 410-547-0915.



The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the MMJ in the event that the work is published.

- **Manuscript preparation**—Manuscripts should be submitted to Editor, MMJ, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of

corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- **Permissions**—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the MMJ to reproduce the information/figure.

- **Editorial responsibility**—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

Accepted manuscripts become the permanent property of the MMJ and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

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| | |
|---------------------------------|---------|
| Pancreatic cancer—New therapies | Oct. 20 |
| Boundary issues | Oct. 27 |
| Pediatric urology | Nov. 3 |
| Tumor conference | Nov. 10 |
| OB/GYN topic | Dec. 1 |
| Tumor conference | Dec. 8 |
| Infectious disease topic | Dec. 15 |

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

| | |
|--|-------------------------------|
| Diabetic retinopathy and venous occlusive disease. | Oct. 21–22 |
| Second colloquia and workshop on laryngeal disorders, optional hands-on laboratories. Cat 1 AMA credits available. Fee: \$500 lectures; \$500 each additional lab; \$200 lectures for fellows and allied health professionals. | Oct. 24–26 |
| Advances in orthopaedic biomechanics and their clinical applications. 19 Cat 1 AMA/PRA credits. Fee: \$250 presymposium workshop; \$450 symposium; \$250 residents and full-time students. | Oct. 27–30 |
| Update on sinusitis for the practitioner. | Oct. 28 |
| Advanced pediatric life support courses, 20 Cat 1 AMA credits. Fee: \$525. | Oct. 31–Nov. 2; June 12–14 |
| Progress in pediatrics, 11 Cat 1 AMA credits. | Nov. 4–5 |
| The first century of blastomycosis-fungal infections in immunocompromised hosts, at the Stouffer Harborplace Hotel, Baltimore, MD. 10 Cat 1 AMA credits. Fee: \$150/physicians; \$75/residents. Single day fee available. | Nov. 12–13 |
| Advances in pediatric nutrition, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: \$200/physicians and allied health professionals; \$150/residents and fellows. | Nov. 14–16 |
| Ophthalmic update for the medical practitioner | Nov. 18 |
| Fifth annual neurology for the primary practitioner at the Harbor Court Hotel, Baltimore, MD. 6 Cat 1 AMA credits. | Dec. 3 |
| Seventh annual Wilmer Institute current concepts in ophthalmology, 20 Cat 1 AMA credits. | Dec. 8–10 |
| Memory and reality: Reconciliation. Scientific, clinical and legal issues of false memory syndrome, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: Postmarked before Oct. 1: \$300/professionals; \$125 families (includes 2 family members); postmarked after Oct. 1: \$400/professionals; \$275 families (includes 2 family members). | Dec. 9–11 |
| Basic comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. \$850/labs and lectures; \$325/lectures only. | Jan. 12 |

The Johns Hopkins Medical Institutions (continued)

| | |
|--|-------------------|
| Advanced comprehensive endoscopic sinus surgery , Cat 1 AMA credits available. \$1400/ labs and lectures; \$495/lectures only. | Jan. 13-14 |
| Advances in cardiac diagnosis and treatment , 18 Cat 1 AMA credits. | Jan. 20-22 |
| 1995 Update in the management of age-related macular degeneration , 8 Cat 1 AMA credits. Fee: \$225/physicians; \$125/residents, fellows and allied health professionals. | Jan. 21 |
| 22nd Annual geriatrics symposium: Primary care for the practitioner , at the Stouffer Harborplace Hotel, Baltimore, MD. 20 Cat 1 AMA credits available. | Feb. 2-4 |
| 12th Annual Houston Evertt Memorial Course in urogynecology , 17 Cat 1 AMA credits. | Feb. 24-25 |
| 36th Annual postgraduate institute for pathologists in clinical cytopathology , 136 Cat 1 AMA credits. | |
| Course A (Home Study) | Feb-March |
| Course B (Johns Hopkins Medical Institutions) | April 3-14 |

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Johns Hopkins sports medicine grand rounds.** Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

| | |
|---|-------------------|
| Managing depression and related disorders in the ambulatory setting , at the Stouffer Harborplace Hotel in Baltimore, MD. Info: 410-706-3957. | Oct. 29 |
| Advances in epilepsy , at the Harbor Court Hotel in Baltimore, MD. 5.5 Cat 1 AMA credits. Fee: \$35. Info: Catherine Bowers 410-828-7700. | Nov. 14 |
| R. Adams Cowley 16th annual national trauma symposium , at the Hyatt Regency, in Baltimore, MD. Info: 410-328-2399. | Nov. 16-20 |
| AIDS: A challenge to primary care , at the Convention Center in Baltimore, MD. 11 Cat 1 AMA credits. Fee: \$225. Info: Carol Kowarski, 410-706-8562. | Dec. 2-3 |

Miscellaneous meetings

- 4th annual meeting of the Greater Philadelphia Pain Society: Pain update 1994**, at the Adam's Mark Hotel, Philadelphia, PA. 7 CAT 1 AMA credits. Fee: \$195/physicians; \$170/nonphysicians. Info: 610-664-0809. **Oct. 28**
- Annual business meeting**, sponsored by the Baltimore City Medical Society at UMMS Davidge Hall. 1 Cat 1 AMA credit. Fee: Free. Info: 410-625-0022. **Nov. 3**
- Pain management, the interdisciplinary approach**, sponsored by the Southern Maryland Hospital Center at the Colony South Hotel, Clinton, MD. 7 Cat 1 AMA/PRA credits. Info: 301-899-5754. **Nov. 4**
- Interface: Medicine Psychiatry**, sponsored by Saint Joseph Hospital at the Noppenberger Auditorium, Saint Joseph Hospital, Towson, MD. 6 Cat 1 AMA/PRA/AAFP credits. Fee: \$45/physicians; \$45/psychologists; \$25/house staff, nurses, allied health professionals. Info: Patricia Fuchsluger 410-337-1501. **Nov. 5**
- Evaluation of shoulder dysfunction and pain**, sponsored by the Omni Physical Therapy and Allsports Therapy Center in conjunction with Anne Arundel Medical Center, to be held at the Comfort Inn in Bowie, MD. 3 Cat 1 AMA credits. Fee: \$50. Info: 301-474-6505. **Nov. 12**
- Hemodialyzer reuse in the 1990s**, sponsored by the Association for the Advancement of Medical Instrumentation, at the Crystal City Marriott, Washington, DC. Cat 1 AMA credits available. Fee: \$225/members; \$275/nonmembers. **Nov. 15**
- Recent advances in male infertility**, sponsored by the Greater Baltimore Medical Center at GBMC in Baltimore, MD. 5.5 Cat 1 CME credits. Fee: \$40. Info: 410-828-3670. **Dec. 5**



PHYSICIAN'S RECOGNITION AWARD

During August 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Mirza H. A. Baig, M.D.
Francis X. De Candis, M.D.
Edward W. Ditto, M.D.
Carol W. Garvey, M.D.
Ching-Jou Gou, M.D.
Isis S. Hannallah, M.D.
Rafael Hernandez, M.D.
Charles W. Humphreys, M.D.

Martin Z. Kanner, M.D.
Mohammad Khodabandelou, M.D.
Joseph G. Lanzi, M.D.
David B. Larson, M.D.
Joselito D. Magday, M.D.
Paul A. Matera, M.D.
Robert M. McDonald, M.D.

S. Pathmanathan, M.D.
Peter W. Rieckert, M.D.
Alfred B. Rosenstein, M.D.
Margaret T. Snow, M.D.
Edward E. Wallach, M.D.
Anthony H. Woodward, M.D.
Leonard M. Zullo, M.D.

Miscellaneous meetings (continued)

- Fourth annual spring clinical nephrology meetings primary care nephrology program,** March 24-25
sponsored by the National Kidney Foundation at the Sheraton Washington Hotel,
Washington, DC. Info: 1-800-622-9010.
- Third world congress on stress, trauma and coping in the emergency services professions,** April 19-23
at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311.
- Clinical innovations in OB/GYN ultrasound,** sponsored by Meetings & Management Techniques April 22-23
Plus and The American Institute of Ultrasound in Medicine, at the Lowes L'Enfant Plaza
in Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by
ACOB/GYN. Info: Ann Boehme 516-561-4223.

Continuously throughout the year

- Fluorescein angiography conference,** sponsored by the Retina Center, Saint Joseph Hospital,
Baltimore, MD, first and third Mondays of each month, 8:00-9:00 am. Fee: none.
Info: R. Classon, 410-337-4500.

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral Street
Baltimore, MD 21201
410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a résumé to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

MMJ announcements for physician placements in the classified advertisements are charged at the regular classified advertising rate

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COMING OUT OF THE DARK

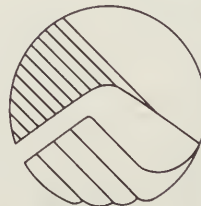
Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families.

The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

Medical
and Chirurgical Faculty
of Maryland



**Physician
Rehabilitation
Committee**



EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

October, 1994

Selected Communicable Diseases in Maryland in 1993 (Continued)

Measles (4)

0.08/100,000 (U.S. 0.1/100,000)

In 1993, the number of measles cases reached an all-time low. The trend in the past 10 years is shown in Figure 11. Two of the cases in 1993 were unvaccinated preschool children, one was a 16 year old exchange student, and one was an adult. The cases occurred in March, April, and June. All were international importations, 3 from Germany and 1 from Ecuador.

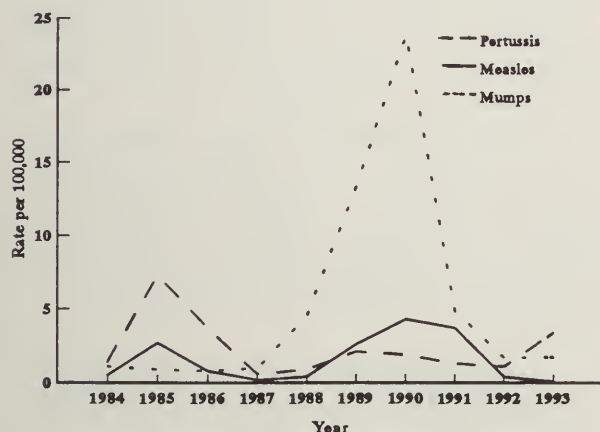


Fig 11. Measles, mumps and pertussis. Incidence, Maryland, 1984-1993.

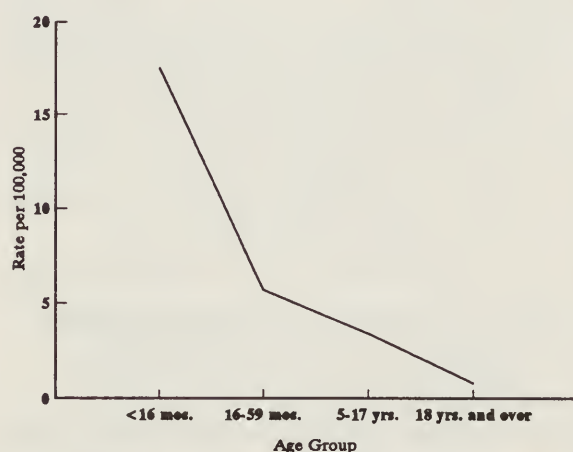


Fig 12. Measles. Incidence by age group, Maryland, 1988-1993.

Meningitis, Viral (Aseptic) (257)

5.2/100,000 (U.S. 4.8/100,000)

The distribution of cases by jurisdiction and the number of cases in 1989 through 1993 are shown in Table 1 (see August, 1994 issue). The highest rate per 100,000 population was observed in Prince George's County. Almost half (47%) of the cases in 1993 occurred in July, August, and September.

The male to female ratio was 0.7:1.0. The ratio of whites to non-whites 2.2:1.0; the race of 20 (8%) cases was unknown. One third (34%) of all cases were 25 to 39 years of age; 37 (14%) were less than 1 year old, including 8 (3%) newborns. The highest rates per 100,000 (15.8 and 13.2) were noted in females, 0 to 4 and 20 to 29 years old, respectively.

The etiology was reported for only 12

The incidence by age group for the 543 cases reported from 1988 through 1993 is shown in Figure 12: 97 (18%) were less than 16 months old, 95 (17%) were 16 to 59 months old, 168 (31%) were 5 to 17 years old, and 183 (34%) were 18 years old and over.

cases: 3 herpes simplex virus 1, 2 herpes zoster, 2 enterovirus (non-typable), 2 coxsackie virus B₄, 1 coxsackie virus A₉, 1 echovirus 6, and 1 cytomegalovirus.

Meningococcal Disease (50)
1.0/100,000 (U.S. 0.9/100,000)

In 1993, the number of cases of meningococcal disease increased by 61% from 1992 (31 cases). Active surveillance and laboratory audits may have contributed to the increase in cases, especially among adults. The number of cases by jurisdiction is shown in Table 1 (see August, 1994 issue). Baltimore City reported more than one third of all cases (34%) and demonstrated the highest rate per 100,000 population in the State (2.3).

The male to female ratio was 1.6:1.0. The ratio of whites to non-whites was 1.4:1.0. Ages ranged from 1 day to 80 years (median 18.5 years). The highest incidence per 100,000 population (5.3) was noted among children less than 5 years of age, followed by the incidence among those 15 to 19 years of age (1.9).

Twenty-six (52%) patients presented with meningitis, 18 (36%) with meningococemia, 4 (18%) with pneumonia, 1 (2%) with arthritis, and 1 (2%) with pharyngitis. Six patients died (a case fatality rate of 16%); 32 cases survived, and the outcome for 7 was unknown.

Mumps (85)
1.7/100,000 (U.S. 0.6/100,000)

The trend in the number of mumps cases over the past 10 years is presented in Figure 11. The number of cases in 1993 by jurisdiction is shown in Table 1 (see August, 1994 issue).

The male to female ratio was 1.7:1.0. The ratio of whites to non-whites was 1.9:1.0. Sixty-two percent of the cases were 5 to 14 years of age. Males, 5 to 9 and 10 to 14 years old, had the highest rates per 100,000, 12.0 and 9.3, respectively.

Pertussis (167)
3.4/100,000 (U.S. 2.4/100,000)

The number of pertussis cases increased by 221% from 1992 (52 cases). This is the first increase in the past 5 years. The trend in the past 10 years is presented in Figure 11. The number of cases by jurisdiction in 1993 is shown in Table 1 (see August, 1994 issue). Forty-two percent of the cases were from the Baltimore metropolitan area (including Anne Arundel County) and an additional 31% were from the Montgomery - Prince George's counties area. An outbreak in an independent, co-educational school in Montgomery County involved 22 students and staff, and 2 close contacts of the students; one of the students was not a Maryland resident.

The male to female ratio was 0.8:1.0. The ratio of whites to non-whites was 3.6:1.0. Ages ranged from 10 days to 53 years (median 18 months). Almost one half of the cases (47%) were less than 1 year of age, including 9 newborns and 52 (31%) 1 to 5 months old. The highest rate per 100,000 population (100.3) was observed in children under 1 year old, followed by the rate in 1 to 4 year olds (10.6). The actual rates probably greatly exceed these rates, since many cases of pertussis go unreported.

The following symptoms were reported: paroxysmal cough in 141 (84%) cases, post-tussive vomiting in 99 (59%), whoop in 70 (42%), cyanosis in 43 (26%), and apnea in 41 (25%). No deaths were reported.

Fifty-six cases (34%) were culture confirmed; of these 31 (55%) were also DFA positive. Seventy-nine (47%) were culture negative, 28 (17%) were not tested, and the status of 4 (2%) was unknown. In the past 5 years (1989 - 1993) 44% of the cases were culture positive, 26% culture negative, and 30% unknown.

Post-Vaccination Adverse Events (59)

In 1993, the number of reported post-

vaccination adverse events decreased by 42% from 1992 (102 events). Twenty-five of the 59 (42%) were DTP (Diphtheria-Tetanus-Pertussis) vaccination related and included 19 serious adverse events in 16 children: 2 deaths, 2 cases with seizures/convulsions, 1 with a tremor/shaking episode, 1 with tachypnea, tachycardia, periorbital edema, and bronchospasm, and 10 cases with screaming /prolonged crying episodes.

Animal Rabies (624)

With the involvement of Somerset and Worcester counties in 1993, all of Maryland became rabies endemic. The trend in the number of cases of animal rabies in Maryland over the past 13 years (since the beginning of the current terrestrial epizootic) is shown in Figure 13. Four southern Eastern Shore counties (Dorchester, Somerset, Wicomico, and Worcester) accounted for 49% of all cases. It is typical and expected that large numbers of cases are confirmed in the first and second years of involvement. The number of cases by jurisdictions is shown in Table 1 (see August, 1994 issue).

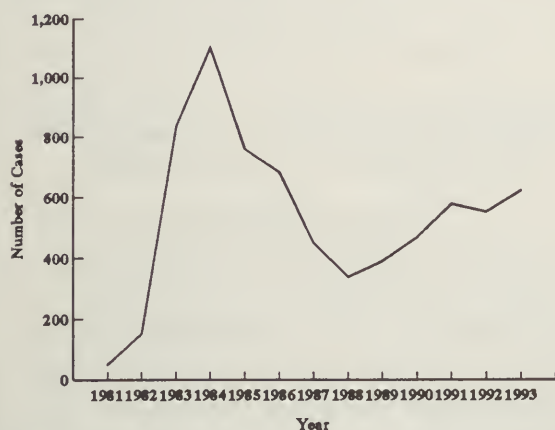


Fig 13. Animal rabies. Cases reported, Maryland, 1981-1993.

In 1993, 624 of the 5448 animals submitted for laboratory examination were rabies positive. Raccoons continue to be the most frequently reported animal (500, 80.1%) because it remains the maintenance host. Other significant spillover species reported with rabies were skunks (59, 9.5%),

foxes (21, 3.4%), cats (21, 3.4%), bats (9, 1.4%), dogs (3, 0.5%) and horses (2, 0.3%). Since rabies became endemic in Maryland (1981), 152 rabid cats and 16 rabid dogs have been confirmed. The cat represents an important source of rabies exposure to humans; an investigation of 31 rabid cats in Maryland between January 1983 and May 1996, showed that each rabid cat exposed an average of 6.3 persons. There has been no human death due to rabies in Maryland since 1981 when the raccoon rabies epidemic reached the state. However, the risk of human exposure from rabid animals continues to be high. Because rabies is a fatal disease, avoiding exposure and prompt postexposure treatment for the person exposed, if required, continues to be the best means of preventing deaths.

Rocky Mountain Spotted Fever (23) 0.5/100,000 (U.S. 0.2/100,000)

The number of cases in the past 5 years and by jurisdiction in 1993 is shown in Table 1 (see August, 1994 issue). While 9 (39%) of the cases occurred in the Eastern Shore area, none were reported from the counties west of Baltimore County.

Onsets of illness were in May through November; June and July were the peak months with a total of 15 (65%) cases.

The ages of the cases ranged from 16 months to 69 years (median 27 years). The male to female ratio was 2.3:1.0. All cases were among whites. Males, 10 to 14 and 50 to 59 years old, had the highest rates per 100,000 population, 1.9 and 1.3, respectively.

Eighteen (78%) patients had a rash, including 5 with rash on the palms and/or the soles; 4 (17%) confirmed cases did not have a rash. No deaths were reported.

Sixteen (70%) patients had a tick bite, 2 (9%) had visited tick infested areas, 3 (13%) had no history of exposure, and 2 had no exposure information available.

Rubella (2)

0.04/100,000 (U.S. 0.07/100,000)

The reported rubella cases were both in adults. No further spread was noted.

Salmonellosis (1028)

21.0/100,000 (U.S. 16.1/100,000)

The trend in the number of cases of salmonellosis over the past 10 years is presented in Figure 14. The number of cases by jurisdiction in 1993 is shown in Table 1 (see August, 1994 issue). More than half (53%) of the cases had an onset in July through October (peak month September with 173 cases). Ten outbreaks of salmonellosis were reported by 6 counties: 7 were caused by *S. enteritidis* (129 cases), 1 by *S. typhimurium* (108 cases), 1 by *S. infantis* (35 cases), and 1 by *S. unspecified* (2 cases).

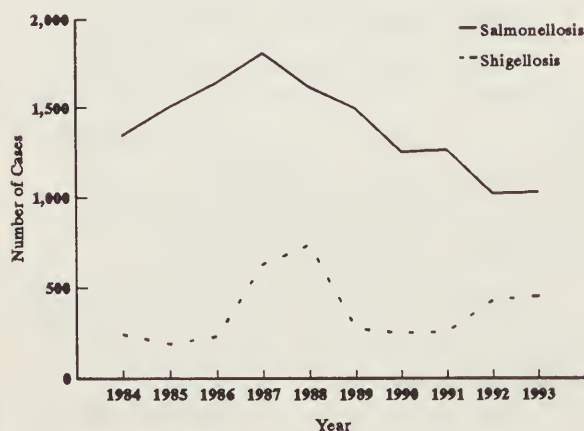


Fig 14. Salmonellosis and shigellosis. Cases reported, Maryland, 1984-1993.

The male to female ratio was 0.9:1.0. Among the 703 cases for whom the race was known, the ratio of whites to non-whites was 1.2:1.0. Children less than 1 year of age had the highest rate per 100,000 population (180.3), followed by the rate in age group 1 to 4 (60.4). Among adults the highest rates were in age groups 20 to 29 (16.5) and 30 to 39 (15.7).

Of the 666 (65%) isolates for which serotypes were available, 229 (34%) were *S. enteritidis* (compared to 30%, 37%, and 40% in 1990, 1991, and 1992, respectively), 164 (25%) *S. typhimurium*, 32 (5%) *S. heidelberg*, 30 (5%) *S. hadar*, 25 (4%) *S. newport*, 21 (3%) *S. braenderup*, and 165 (25%) other serotypes.

Shigellosis (453)

9.2/100,000 (U.S. 12.5/100,000)

The number of cases by jurisdiction is shown in Table 1 (see August, 1994 issue). The trend in the number of cases of shigellosis over the past 10 years is presented in Figure 14. In 1993, there were 9 outbreaks of shigellosis which occurred in 5 counties.

The male to female ratio was 0.9:1.0. The ratio of whites to non-whites was 1.3:1.0; the race of 130 (29%) was unknown. The highest rates per 100,000 population were noted in age groups 1 to 4 years (40.2), 5 to 9 (26.6), and under 1 year of age (15.2).

Of the 400 (88%) isolates for which the species was known, 337 (84%) were *S. sonnei*, 55 (14%) *S. flexneri*, 5 (1%) *S. boydii*, and 3 (1%) *S. dysenteriae*.

Syphilis, primary and secondary (393)

8.0/100,000 (U.S. 10.3/100,000)

In 1993, the number of primary and secondary (P & S) syphilis cases decreased by 33% from 1992 (590 cases). Figure 15 shows the trend of P & S syphilis incidence in Maryland over the past 10 years. The number of cases in 1993 by jurisdiction is presented in Table 1 (see August, 1994 issue). Baltimore City (179 cases) reported 46% of all cases.

The male to female ratio was 1.6 to 1.0. Eighty-five percent of the 283 cases for which race was specified were black. Sixty-one percent of the cases were 20 to 34 years old.

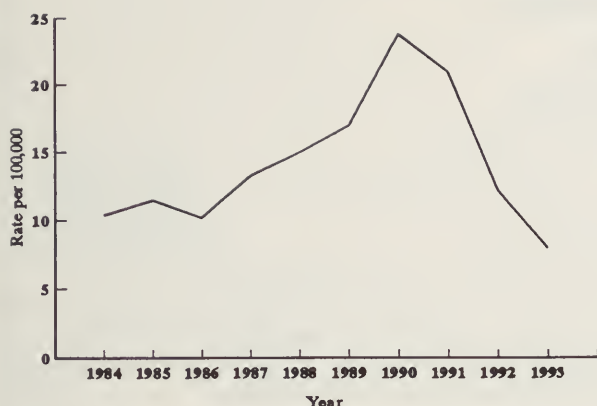


Fig 15. Primary and secondary syphilis. Incidence, Maryland, 1984-1993.

Since 1988, all P & S syphilis and early latent syphilis patients seen in public STD clinics have been offered testing for HIV. The percent of co-infection in those tested was 18% (66/372) in 1988, 16% (96/601) in 1989, 7% (69/974) in 1990, 11% (94/871) in 1991, 11% (67/624) in 1992, and 8% (35/461) in 1993.

The number of congenital syphilis (36) decreased 42% from 1992 (62). The following jurisdictions reported cases: Prince George's County (18), Baltimore City (11), Montgomery (3), Anne Arundel (1), Calvert (1), Howard (1), and Wicomico (1).

Tuberculosis (417)

8.4/100,000 (U.S. 9.8/100,000)

The number of tuberculosis cases declined slightly from 1992 (442 cases). The number of cases in the past 5 years and by jurisdiction in 1993 is shown in Table 1 (see August, 1994 issue). Baltimore City, Montgomery and Prince George's counties reported 29%, 27%, and 17%, respectively, of all cases in 1993. While in most counties the rates per 100,000 population decreased from 1992, Montgomery County's rate increased from 12.8 in 1992 to 13.6 in 1993.

The male to female ratio was 1.5:1.0. The ratio of whites to non-whites was

1.0:2.5. There were 25 (6%) cases in children under the age of 15 years and 114 (27%) who were 65 years old and older. Thirty-seven percent of all the cases were foreign born.

A match of the tuberculosis and AIDS registries for 1993 identified 41 (10%) persons with both infectious diseases, compared to 60 (14%) in 1992, 36, (8%) in 1991, and 41 (11%) in 1990. Thirty-four (83%) of the HIV infected were black, 6 (15%) were white, and 1 (2.4%) were Hispanic.

Drug resistance has not emerged as a significant problem. In 1993 only 13 (3%) of the reported cases were INH resistant and not rifampin resistant, and 4 (1%) was resistant to at least INH and rifampin.

Directly observed therapy (DOT) is a high priority public health strategy in Maryland. This involves observation by trained health care workers of every dose of medication taken. Sixty percent of the patients diagnosed in 1993 received DOT, compared to 33% in 1992.

Typhoid Fever (8)

0.2/100,000 (U.S. 0.2/100,000)

Cases of typhoid fever were reported from Baltimore (3), Prince George's (2), Anne Arundel (1), Montgomery (1) counties, and Baltimore City (1).

The male to female ratio was 1.0:1.0. Four cases were Asian, 3 Hispanic, and 1 white. Ages ranged from 7 to 56 (median 27.5 years).

The cases were imported from the Philippines (2), Pakistan (2), India (1), and Mexico (1); the source of infection for 2 cases was not specified.

Corrections: In Table 1 (August, 1994 issue) the number of hepatitis B cases in Dorchester County should have read 9, the 1993 hepatitis B total - 288, the number of malaria cases in Howard County - 4, and the 1993 malaria total - 57.

Hospital Medical Staff Section 24th Assembly Meeting December 1-5, 1994 Sheraton Waikiki Hotel Honolulu, Hawaii

Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses;
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

Plan to participate in the Federation Consortium on Friday, December 3 from 2:30 to 5:30 pm in Honolulu, Hawaii. Maha!o!

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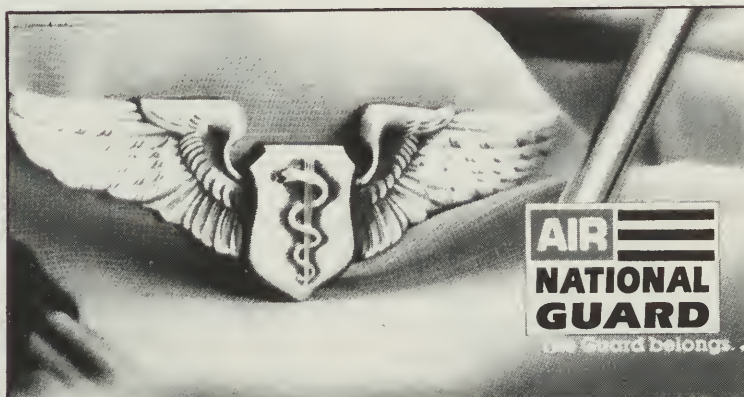
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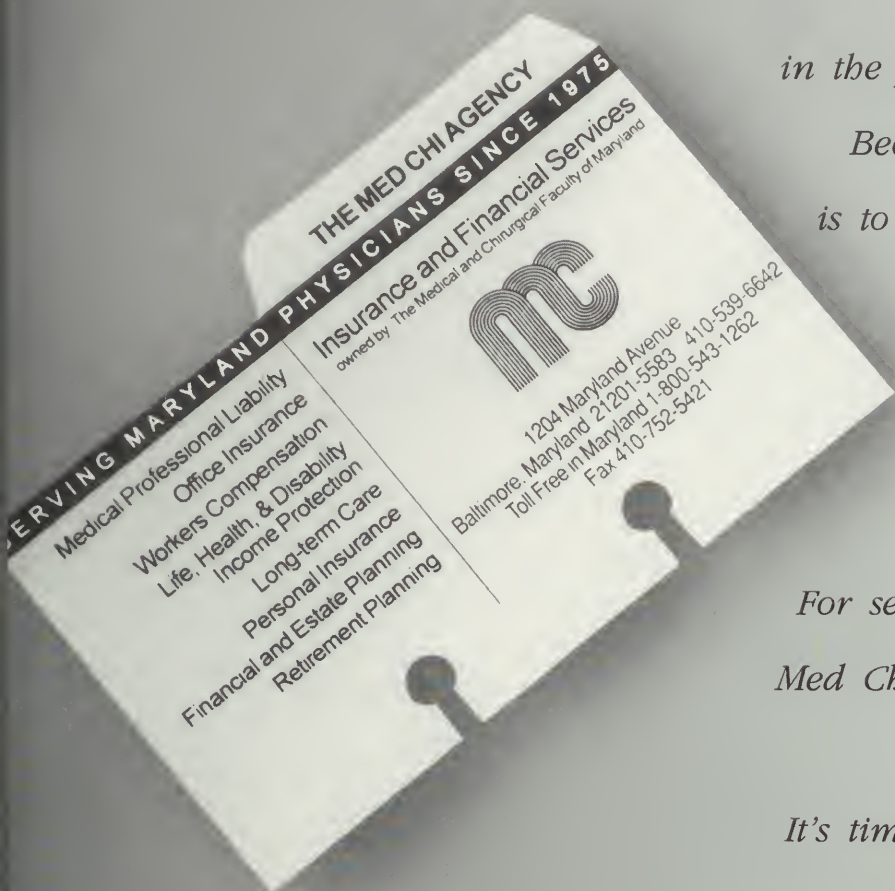
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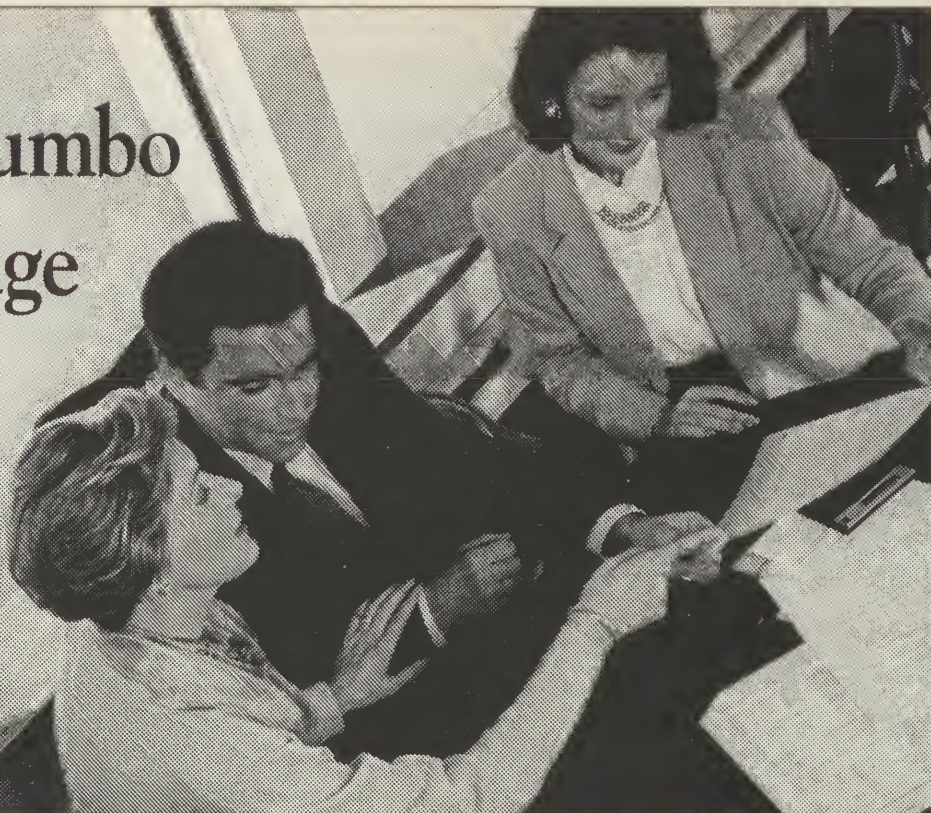
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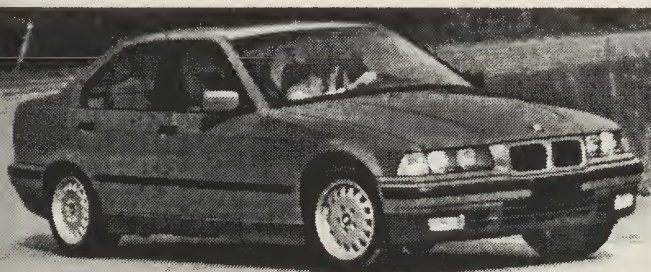


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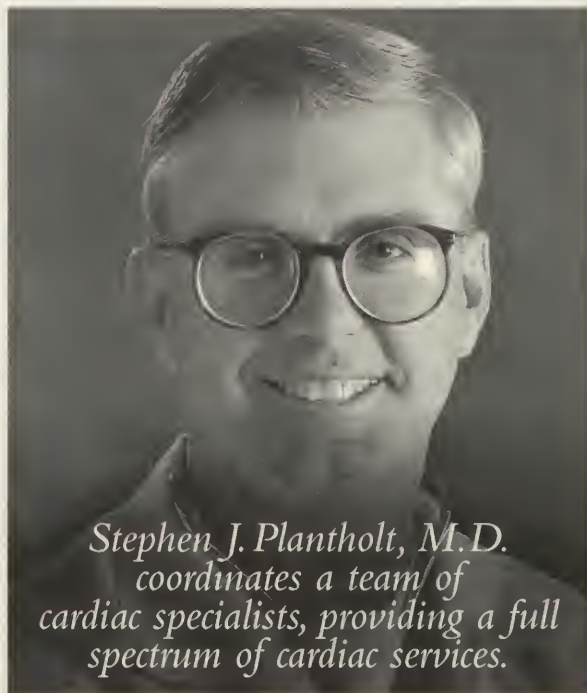
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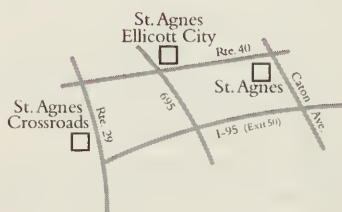
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Gold Resigns from Maryland Medicare

Barry S. Gold, M.D., F.A.C.P., resigned his position as Medical Director for Maryland Medicare as of November 1, 1994. A letter written to Maryland providers by Dr. Gold follows this issue of the *Chief Executive Officer's Newsletter*.

PBS Medicare Electronic Services Department

In the near future, the Medicare Electronic Services department at Pennsylvania Blue Shield (PBS) will add new features to the Medicare Provider Inquiry (MPI) network. MPI will be expanded to include an electronic bulletin board and mail services to increase the providers, "electronic advantage" and to reduce the time and money they spend conducting Medicare business.

The new capabilities that MPI will feature are:

- electronic filing of claim review requests;
- electronic filing of requests for general information and copies of payment vouchers;
- electronic filing of address changes; and
- electronic RSVPs to Medicare Electronic Services and Medicare Professional Services provider seminars.

PBS also plans to add electronic features to MPI after the initial expansion of service to include:

- electronic browsing and retrieval of Medicare publications;
- electronic retrieval of complete Medicare fee schedules and limiting charges;
- electronic filing of Freedom of Information Act requests.

According to PBS, providers who currently use MPI will automatically receive access to the new services. Providers who bill electronically will need to sign up for the services. PBS forwarded reply cards to providers for this purpose.

New Mammography Guidelines Issued

New clinical practice guidelines recommend ways to improve the quality of mammography and its potential for reducing deaths from breast cancer. The guidelines, issued by the Public Health Service's Agency for Health Care Policy and Research (AHCPR), clearly outline the roles and responsibilities of each health worker involved in the mammography process and of the woman undergoing mammography. Single copies of "High-Quality Mammography - Information for Referring Providers: Quick Reference Guide for Clinicians" are available free from the AHCPR Publications Clearinghouse at 1-800-358-9295. It is also available free by AHCPR Instant Fax (301-594-2800) 24 hours a day, seven days a week.

**1995 CPTs and ICDs
Available**

The Med Chi Library has copies of both the 1995 CPT and the 1995 ICD available for purchase. The prices are as follows:

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| CPT 1995 (book and Clinical Examples Supplement only, soft bound) | |
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| ICD-9-CM (St. Anthony's Code Book for Physician Payment, v. 1 & 2 in one volume, compact soft bound) | |
| Member | \$33.00 |
| Nonmember | \$43.00 |

The Library does not carry mini-books or any other versions of these items. All orders must be prepaid. The items can be picked up during business hours or sent UPS; the prices remain the same. Please send a check or money order (made payable to the Med Chi Library), to 1211 Cathedral Street, Baltimore, MD 21201, attn: Angie Jancius. For further information, please call the library at 410-539-0872 or 1-800-492-1056.

**AMA Issues Opinion
on Methotrexate and
Misoprostol for
Abortion**

The American Medical Association (AMA) recently issued the following opinion on the use of methotrexate and misoprostol for abortion: "Recent reports have suggested that methotrexate and misoprostol may be an effective and safe method of abortion. It is premature for physicians to offer this method to their patients unless the physician and patient are involved in experimental trials that fully meet ethical and scientific standards for research protocols. Even though both drugs have been approved for use by the Food and Drug Administration, they have not undergone sufficient testing together to warrant their general use for abortion. The AMA understands the motivation of physicians to offer their patients treatments that seem preferable to conventional treatments. Many advances in drug therapy occur through such motivations. Given that adverse side effects of drugs are often not discovered in the early stages of testing, it may be prudent to await more data. In this case, we believe that it may be inappropriate to generally use this combination of drugs for abortions without further testing." For more information, contact: Jack Segal, AMA Senior Public Information Officer, at 312-464-5360.

**Med Chi Seeks
Physicians for Sunday
Rounds Radio
Program**

Sunday Rounds is a weekly radio program, hosted by John Stupak and sponsored by Med Chi, that airs on WBJC (91.5 FM) from 7:00 p.m. - 8:00 p.m., Sunday evenings. Med Chi physicians are invited to participate in this program, which is aimed at providing the public with information on current health topics. Scheduling for 1995 has now begun. If you are interested in being a guest on *Sunday Rounds*, please call Heather Johnson at 410-539-0872, ext. 306.

**Free Surgery for
Victims**

Many victims of domestic violence receive severe facial injuries and for financial reasons and/or feelings of shame and low self-esteem are not able to receive adequate care. The American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), in partnership with the National Coalition Against Domestic Violence (NCADV), created The National Domestic Violence Project. Through this project, free facial plastic and reconstructive surgery will be provided to victims of domestic violence. The Project has a centralized information center accessible through a toll-free number, 1-800-842-4546, which provides the names

of surgeons in a victim's area who will provide free consultation and perform surgery if necessary. There are several physicians in Maryland participating in this project.

***Volunteers Needed for
Eye Study***

Johns Hopkins researchers studying a treatment that may prevent or delay a blinding disease are seeking people between the ages of 40 and 80 who have ocular hypertension — abnormally high pressure in the eye — or believe they are at risk. People at greatest risk include those who have diabetes or high blood pressure, are nearsighted, have a family history of glaucoma, or are of African ancestry. The five-year study is designed to resolve a debate over whether doctors should treat ocular hypertension or take a "watch-and-wait" approach. The study coordinator, Rachel Scott, can be reached at 410-955-5818.

***BC/BS of Maryland
Offers Open
Enrollment***

BlueCross BlueShield of Maryland(BC/BS) is offering open enrollment for individuals and their families who might not otherwise qualify for health insurance because of pre-existing medical conditions. BC/BS's FreeState Health Plan HMO will accept applications from October 19 to November 28 with an effective date of December 1, 1994, and the Columbia Medical Plan HMO will accept applications from November 21 to December 30 with an effective date of January 1, 1995. For more information dial 1-800-544-8703.

***MMJ Best Article
Award***

During the 1994 semiannual meeting, *The Maryland Medical Journal (MMJ)* announced the winner of the eighth annual Best Article Award for the most outstanding article published during 1993. Cynthia M. Lipsitz, M.D., M.P.H., director of the Bureau of Personal Health, Howard County Health Department, Columbia, Maryland, won for "Have you come a long way, baby? Smoking trends in women," which was published in January 1993.

***Medical Acupuncture
Speakers Available***

The Maryland Society of Medical Acupuncture (MSMA), co-sponsored by Med Chi and the American Academy of Medical Acupuncture, will provide speakers for component medical societies who are interested in presentations on medical acupuncture. For additional information, or to arrange for a speaker, call Margaret M. Mullins, M.D., MSMA president, at 410-757-7665.

***BC/BS Initiates
Speakers' Bureau***

BlueCross BlueShield of Maryland has formed a Speakers' Bureau to address health care reform. Speakers will focus on President Clinton's Health Care Security Act of 1993 and explain BC/BS's position on health care reform at both the state and national level. Organizations interested in scheduling a speaker can contact Teresa Adelman at 410-998-5521.

Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

BARRY S. GOLD, M.D., P.A.
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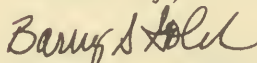
Dear Colleagues:

Effective 11/1/94, I resigned my position as Consultant Medical Director for Maryland Medicare. I would like to take this opportunity to extend my heartfelt thanks to my colleagues in the provider community for their invaluable support and cooperation extended to me throughout the past six years.

Since assuming the position in 1988, it has been my firm belief that my effectiveness as Medical Director has been directly related to my ability to understand the problems inherent in the day to day practice of medicine. This has been accomplished by my job description as a "full-time equivalent" Medical Director which has allowed me to remain active in the practice of Medicine while performing my duties with Medicare. I discussed my continuation in this administrative position with the Medical Director for Texas, who was intransigent in the requirement that the position be held by a "full-time" Medical Director. In view of the turbulent health care atmosphere, I am reluctant to forfeit my active clinical practice for a full-time position with the Texas carrier which was offered for only a one year tenure.

In my capacity as Medical Director with Maryland Medicare, I had the pleasure of working with countless health care providers in Maryland and throughout the country. I worked closely with professionals at the HCFA, AMA and other professional societies and was able to positively impact National health care policies. I am perhaps proudest of the solid relationship which I had built between Medicare and the Med-Chi Faculty.

Sincerely,



Barry S. Gold, M.D., F.A.C.P.

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Med Chi and health system reform

The leadership must be praised for bringing Med Chi into a pro-active and positive agenda with the potential to cope successfully with the emerging chaos facing medicine. Maryland physicians and their patients benefited from several groundbreaking decisions at the July 1994 House of Delegates meeting.

The news that Arnold Levy, M.D., with the Montgomery and Prince Georges County medical societies, reversed a retrospective Medicare decision to require reimbursement of \$2 million to accommodate a mistake made by the intermediary is certain testimony that Med Chi does serve the practicing physician.

The viable and historic establishment of a Med Chi-sponsored IPA [independent practice association] controlled by physicians promises new hope to all of us committed to patient advocacy. The upcoming campaign to inform the public about the inherent fallacies of uncontrolled managed care companies that use their intimidating power over physicians to squelch dissent and establish de facto rationing based on economic considerations is absolutely essential to the passage of the Patient Protection Act nationally and "any willing provider" legislation statewide.

Also essential to productive involvement in health system reform was the passage of a resolution requesting the AMA to advise all legislators promoting a single-payer system of those features that would be acceptable to physicians and the American public. I am among a growing group of grassroots physicians becoming more and more convinced that the present

trend of vesting the insurance industry with control over the delivery of medical care is the fatal flaw that is taking this country away from the objectives of fair and affordable health care for all Americans.

The resolution echoes the sentiment and counsel of George S. Malouf, Sr., M.D., an accomplished medical statesman who serves as chairperson of the AMA delegation. Dr. Malouf said, "The single-payer issue is not a heresy and we should continue to talk about it."

I was particularly encouraged by the number of established Med Chi leaders who sponsored the resolution. The way is now open to look at a single-payer system with a more open mind and examine it from the standpoint of what will work. I urge any interested Med Chi member to contact me so that we can continue this process on the level of the state medical society.

Following are some of the reasons single-payer advocates think it will work. The U.S. General Accounting Office (GAO) says that if the United States were to shift to a system of universal coverage and a single payer, the savings in administrative costs would be more than enough to offset the expenses of universal coverage.¹ The cost of serving the newly insured and eliminating copayments and deductibles would be \$64 billion, but the savings in insurance overhead and administrative costs would be \$67 billion. Whether this assumption is true clearly merits closer analysis, but simplification of the system away from the present format of brokering health care is obviously desirable.²



A recent AMA report on single payer outlines excellent criteria and a good starting point to fulfill the purpose of the resolution.³ The McDermott-Wellstone bills also represent an opportunity to preserve the patient's choice of physician, keep treatment choices between the physician and the patient, and eliminate the demeaning dynamics of the gatekeeper psychology and micro-management by the insurance purveyor.^{4,5} Outliers and practice guidelines would be used for utilization and quality assurance purposes. Physicians, through the mechanism of organized medicine, would negotiate fees on the basis of a fair price for health care. Budgets and fees would be subject to the influences of our physician spokespersons, not the "take it or leave it" dynamic that has emerged from insurance-driven systems. It is hoped that the resolution will identify what is acceptable in these legislative proposals and what should be changed.

The single payer is seen as the last chance for the survival of fee-for-service for all physicians, not just some.⁶ It is the best way to prevent putting physicians in the quandary of not knowing what to do when health plans no longer want them.⁷ A growing number of medical organizations are giving single-payer their support.⁸

The rapid trend toward the institutionalization of medicine will be modi-

fied if a single-payer plan prevails. Will the traditional physician-patient relationship so central to practicing the art of medicine become obsolete? Will America remain the land of opportunity for physicians or for managed care insurers?

Many thanks to the resolution sponsors. It is nice to know I may not be a medical heretic after all.

WAYNE C. SPIGGLE, M.D.
Cumberland, Maryland

*Dr. Spiggle is president-elect of the
Allegany County Medical Society*

References

1. General Accounting Office. *Canadian Health Insurance. Lessons for the United States*. GAO/HRD-91-90.
2. Angell M. How much will health care reform cost? *N Engl J Med* 1993; 328:1178-1179.
3. Bristow LR. Single-payer health system (resolution 151, I-93). *AMA Board of Trustees Report* 46-A 94.
4. McDermott J. Evaluation of health system reform. *JAMA* 1994;271:782-784.
5. Wellstone PD, Shaffer ER. American Health Security Act—a single payer approach. *N Engl J Med* 1994;328: 1489-1493.
6. Inglehard JK. The struggle between managed care and fee-for-service practice. *N Engl J Med* 1994;331:63-67.
7. Terry K. When health plans don't want you anymore. *Medical Economics* June 1994;24-31.
8. Cotton P. Single-payer plan gets cautious support. *JAMA* 1994;271:731. ■

LETTERS TO THE EDITOR

The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

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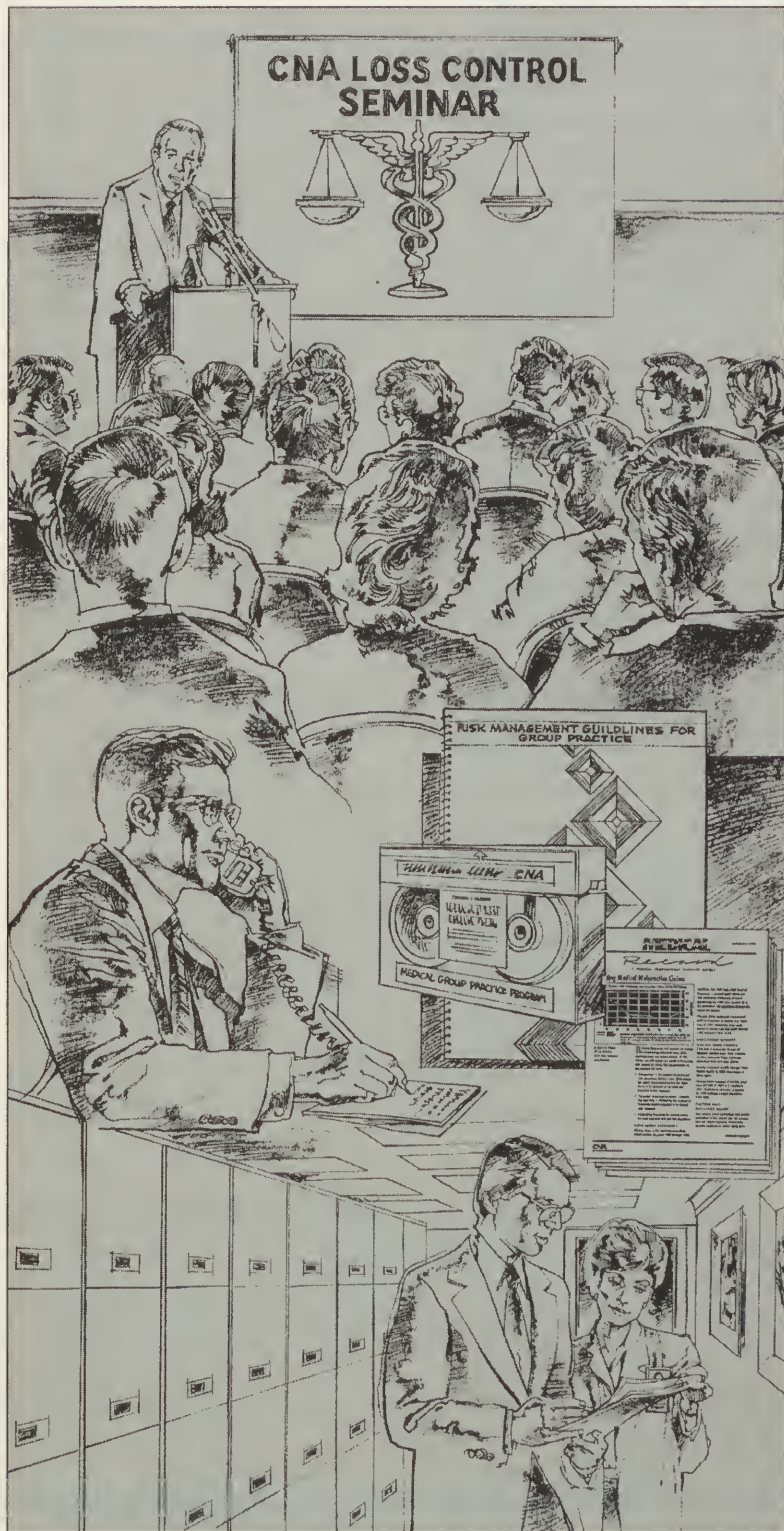
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Cancer mortality in Maryland: when being a leader is not best

Melissa J. Gamponia, M.D., M.P.H., Ronald W. Joines, M.D., M.P.H.,
Peter L. Beilenson, M.D., M.P.H., and Andrew L. Dannenberg, M.D., M.P.H.

Dr. Gamponia is in the preventive medicine residency program at The Johns Hopkins University School of Hygiene and Public Health in Baltimore, Maryland. Dr. Joines is associate medical director for occupational medicine at SmithKline Beecham Laboratories in Philadelphia, Pennsylvania. Dr. Beilenson is commissioner of the Baltimore City Health Department. Dr. Dannenberg is director of Hopkins' preventive medicine residency program.

ABSTRACT: *Maryland has the second highest statewide cancer mortality rate in the nation. This ranking is primarily due to high death rates for the most prevalent cancers: lung, breast, colon, and prostate. Based on the recent literature and the October 1991 preventive medicine grand rounds at the Johns Hopkins University School of Hygiene and Public Health, this paper summarizes several current viewpoints on cancer mortality in Maryland and the progress that has been made by recently instituted state and community initiatives.*

Overview

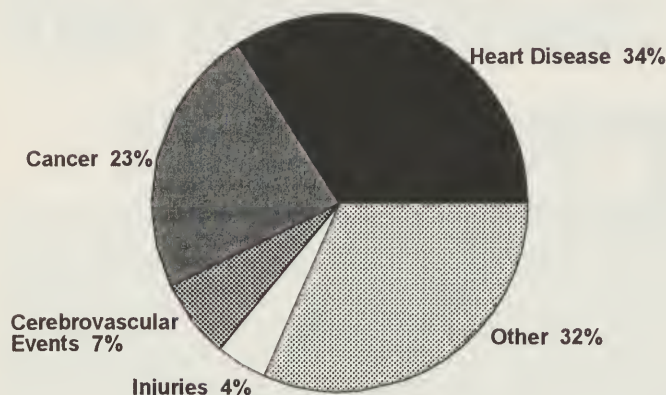
Cancer is the second leading cause of death in the United States (**Figure 1**). In addition, the age-adjusted death rate from cancer in the United States has risen steadily over the past five decades. This rise in cancer death rate nationally is paralleled in Maryland, where the average cancer death rate has remained significantly higher than the U.S. average since the 1950s. In Maryland, an estimated 10,100 deaths in 1993 were attributed to cancer.¹

From 1983 to 1987, Maryland had the highest statewide cancer mortality rate in the country. Maryland's current cancer mortality rate of 193 deaths per 100,000 persons per year is the second highest of all states, exceeded only by Delaware (195 deaths per 100,000 persons per year) and the District of Columbia (230 deaths per 100,000 persons per year). The national cancer mortality rate is 172 deaths per 100,000 persons.² The rates are adjusted for different age distributions among states, but not for race or sex differences. Maryland's high ranking in overall cancer mortality is primarily due to high death rates for the four most prevalent cancers: lung, breast, colon, and prostate (**Figure 2**). These four cancers collectively account for over half of all deaths due to malignancy in Maryland (**Figure 3**).

Lung cancer. In the United States, there were an estimated 170,000 new cases of and an estimated 149,000 deaths due to lung cancer in 1993.¹

REPRINTS: Andrew L. Dannenberg, M.D., M.P.H., Johns Hopkins Preventive Medicine Residency, 624 N. Broadway, Room 545, Baltimore, MD 21205.

Figure 1. Leading causes of death in the United States



Age-adjusted to the 1970 US standard population
Adapted from Cancer Statistics, 1993, ACS

Lung cancer contributes disproportionately to both national and state mortality statistics because of its high case fatality rate. Because well-documented evidence shows that smoking causes lung cancer, these high rates have been attributed primarily to high rates of smoking among state residents. Throughout the 1970s, Maryland had a higher per capita consumption of cigarettes than the nation. This problem continued into the 1980s. Maryland had the fourth highest smoking rate when compared to 25 other states in 1982 and 1986. In 1988, Maryland continued to rank relatively high in tobacco consumption compared to 37 other states.³ Because smoking-related cancers frequently take 20 or more years to manifest, the high mortality rates due to lung cancer are expected to continue beyond the 1990s.

Breast cancer. Maryland ranks 11th in the nation with an annual breast cancer mortality rate of 29.4 deaths per 100,000 persons.⁴ It is estimated that 1 of every 9 women in the United States will develop breast cancer by age 85. Although certain risk factors provide clues in the development of breast cancer, many women may not be able to alter their personal risk factors in any practical sense. Because the five-year survival rate for breast cancer in situ approaches 100%, the best opportunity for reducing mortality is through early detection.¹

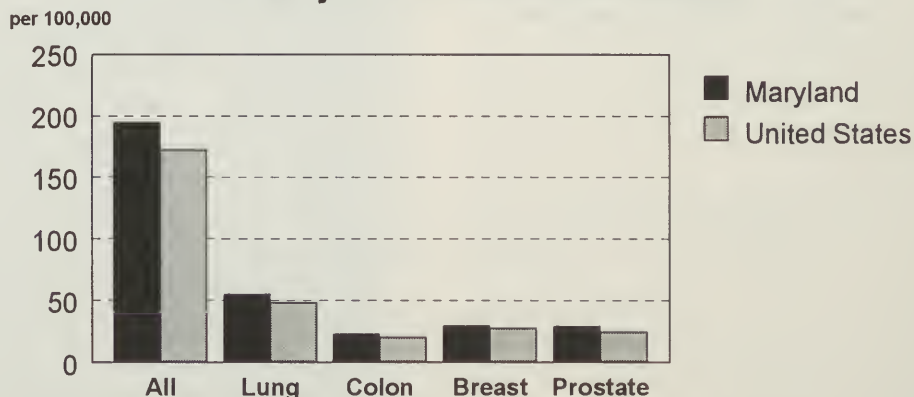
Colorectal cancer. Maryland ranks 10th in the nation for mor-

tality from cancer of the colon and rectum. The state's annual rate is 22.5 deaths per 100,000 persons; the national rate is 19.8 deaths per 100,000 persons.⁴ For the past several years, incidence rates have been decreasing for all age groups except for African American men.¹ Risk factors include personal or family history of cancer or polyps of the colon or rectum, inflammatory bowel disease, and possibly a high-fat and/or low-fiber diet. Clinicians must maintain a high level of suspicion when these risk factors are present in otherwise asymptomatic patients and should properly evaluate any rectal bleeding. For a colorectal cancer of Duke's A classification, the five-year survival rates are 85% to 91%.¹

Prostate cancer. Maryland ranks 7th in the nation with an annual prostate cancer mortality rate of 29.1 deaths per 100,000 persons. The national rate is 24.4 deaths per 100,000 persons.⁴ It is estimated that 1 of every 10 men will develop prostate cancer by age 85. African American men have the highest incidence rate in the world (about 40% higher than the rate for white men¹), but it is unclear whether the higher incidence is due to genetic or environmental factors. As with breast and colorectal cancer, early detection has a significant impact on survival rate, which is 91% for five years if prostate cancer is detected while still localized.¹

Cervical cancer. Although Maryland does not rank high with regard to cervical cancer mortality rates when compared to the national rate, it has the seventh highest rate of sexually transmitted diseases and the 11th highest rate of teenage pregnancy in the United States. The prevalence of such high-risk sexual behavior could potentiate significant cervical can-

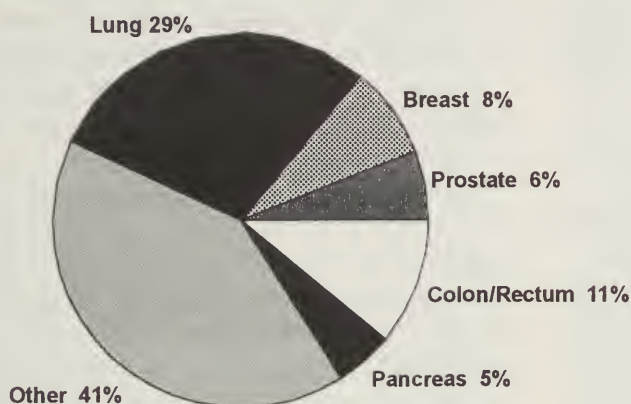
Figure 2. Annual estimated cancer death rates in Maryland and the United States



Based on annual average mortality rate 1985-89, adjusted to the age distribution of the 1970 U.S. census population

Adapted from Cancer Statistics Review 1973-89, NCI, 1992

Figure 3. Maryland cancer mortality 1993



Adapted from Cancer Statistics, 1993, ACS

cer morbidity and mortality within the state.³ In 1993, there were an estimated 4,400 deaths due to cervical cancer and 5,700 deaths from endometrial and unspecified uterine cancer in the United States, including more than 175 deaths in Maryland.² The most important primary prevention methods are abstinence or the use of barrier contraceptive methods to prevent sexual transmission of human Papillomavirus, the etiologic organism for cervical cancer initiation. The Papsmear remains the most effective means of secondary prevention. In patients with in situ disease, the five-year survival rate is almost 100%. By contrast, widely metastatic cervical cancer is associated with a five-year survival rate of only 8% to 10%.¹

Risk factors

Environmental carcinogens. There are clear geographic variations in cancer mortality within Maryland. Between 1983 and 1987, cancer mortality rates exceeded the national average in 20 of the state's 24 counties. There is substantial variability, however, among the counties for deaths classified by cancer site. Breast cancer deaths tend to cluster in southern Maryland, Montgomery County, and Baltimore City. Lung cancer mortality is higher than the national average in Baltimore City and on the Eastern Shore. The etiology of these regional variations remains unclear and merits further investigation.

Environmental factors are known to contribute to cancer of the lung, prostate, bladder, and skin, as well as to non-Hodgkin's lymphoma. Uranium and phosphate-rich geologic formations in certain parts of Maryland are associated with high radon levels.³ Also, in the past, Marylanders working in the shipbuilding, steel, chromium, chemical, and agricultural industries were exposed to established carcinogens such as

asbestos and hexavalent chromates. Although exposure to environmental carcinogens coupled with a high rate of smoking may put such workers at very high risk, these factors alone are not sufficient to fully explain Maryland's high cancer mortality rates.

Doll and Peto⁵ estimated that the contribution to cancer mortality from occupational and environmental exposures is only 5%, which includes the 2% of cancer-related deaths attributable to pollution. On the other hand, Epstein⁶ has pointed out that the effect of carcinogenic environmental exposures on cancer incidence and mortality have been greatly underestimated. Davis and Hoel⁷ confirm that recent cancer patterns in industrialized countries cannot be explained solely by aging, smoking, or diagnostic technology/ascertainment error and that it is worth considering the risk of exposure to

chemical carcinogens in the search for the etiology of the most recent cancer patterns. Given the controversial nature of cancer risk assessment associated with potential chemical carcinogens and the problems in extrapolation from animal studies to human populations, the health impact of exposure to radon, pesticides, and other substances is difficult to quantify.

Socioeconomic status. It has been suggested that low socioeconomic status (SES), associated with lower health care utilization and adverse lifestyle behaviors, may contribute to cancer mortality. If low SES is a prime determinant of cancer deaths in Maryland, the incidence of other poverty-associated diseases also should be higher statewide. However, Maryland's mortality rates from other health conditions linked to low SES, such as injury and atherosclerosis, are substantially below national rates. In fact, only heart disease mortality exceeds the national average. The most likely common denominator for high heart disease and cancer mortality rates is rising cigarette consumption within the state over the past several decades. This evidence, coupled with Maryland's top quintile ranking in national per capita income, makes it unlikely that factors associated with low SES are a major contributor to cancer mortality in Maryland.

Race. The annual cancer mortality rate for African Americans in Maryland is 246 deaths per 100,000 persons; for whites, it is 184 deaths per 100,000 persons. Although the overall cancer mortality rate is approximately one third higher for African Americans than for whites,³ the difference does not have a substantial influence on Maryland's high ranking because it parallels national patterns.

Current cancer prevention policy in Maryland

Although the Department of Health and Mental Hygiene (DHMH) has focused on the primary prevention and early detection of cancer, in the past the impact of existing services appeared to be limited by poor access and utilization. As a result, several initiatives have been developed to address these issues.

Gynecologic screening. In 1991, laws were enacted that mandate private insurance and Medicaid coverage of screening mammography for Maryland residents.^{8,9} The DHMH has worked with the Health Services Cost Review Commission (HSCRC) to expand access to low-cost mammography through local medical institutions. The hospital-based program for breast and cervical cancer screening, which uses American Cancer Society (ACS) guidelines, provides for mammography, clinical breast examinations, and gynecologic examinations with Pap smears for women aged 40 or older who are underinsured or uninsured. When clinically indicated, the program also provides for diagnostic follow-up, including biopsy. These services are performed with little or no charge to patients. The 28 participating hospitals were selected by the HSCRC Illness Prevention Program and have rate adjustments for reimbursement.

A similar program funded by the Centers for Disease Control and Prevention (CDC) is run by local health departments throughout Maryland. It provides breast and cervical cancer screening for women aged 50 and older in accordance with the National Cancer Institute's policy for routine mammographic screening in asymptomatic women. The local health departments also provide colposcopy for younger women who had Pap tests elsewhere but need more extensive follow-up and treatment. These programs do not supplant other programs, such as local health department family planning programs that target a younger population. Participating physicians and hospitals are reimbursed by state funds and the CDC.

Socioeconomic programs. Despite the expanded availability of screening services, primary and secondary preventive care remain underutilized, particularly among persons in the lower socioeconomic strata. American Cancer Society findings indicate that economically disadvantaged people generally endure greater suffering from cancer than other Americans. Facing substantial obstacles in obtaining and using health insurance, they often must make extraordinary sacrifices to obtain and pay for medical care. In addition, cancer education programs may not be culturally sensitive or relevant to the context in which they live. Finally, fatalism about cancer may prevent them from seeking appropriate care in a timely manner.¹⁰

To counter these problems, the North Central Maryland Area Division of the ACS provides a wide variety of services and rehabilitation programs, such as public and professional education programs and limited financial assistance to medically needy cancer patients for reimbursement of mileage to and from treatment facilities. The ACS also participates in minority outreach programs.

Data gathering. Maryland is one of several states that participates in the Behavioral Risk Factor Survey (BRFS) funded by the CDC. Survey information is compiled into a national database for geographic health needs assessment. The primary objective of the BRFS is risk reduction through the development of policies that focus on the national health objectives for the year 2000, including assessment of smoking prevalence and medical screening for breast and cervical cancer.

Before 1991, Maryland used several longstanding hospital registries, one county-wide registry, and a voluntary statewide registry to track cancer. In July 1991, the DHMH, through the state legislative process, established a mandatory statewide registry to record data on cancer incidence.

Environmental measures. The Maryland Department of the Environment (MDE) has acted to reduce cancer risks in the state by implementing increasingly stringent control measures. Limits on automobile emissions have become the state's leading air pollution priority. There also have been statewide advances in waste water treatment: as of 1991, 100% of Maryland waste water treatment plants met or exceeded federal standards for effluent, compared to only 29% compliance in 1984. Finally, the MDE has prompted 98% of Maryland industrial facilities to comply with waste discharge regulations. Although these accomplishments are impressive, their impact on cancer mortality in Maryland is nevertheless difficult to quantify.

The State Council on Cancer Control

A multidisciplinary team composed of leading representatives from the public, private, and medical sectors, the State Council on Cancer Control is charged with the development of a comprehensive program for cancer prevention, screening, and surveillance. It uses four specific decision criteria to select interventions. First, the program focuses on cancers with the highest incidence, prevalence, and case fatality rates. Second, secondary and tertiary care oncology systems are refined to achieve short-term reductions in mortality. Third, primary¹¹ and secondary prevention is emphasized for long-term reductions in cancer incidence and mortality. Finally, all selected interventions must be medically effective and economically and politically feasible. Based on these criteria and known risk factors for cancer, the Council has outlined six broad priorities:³

- prevention and cessation of tobacco use;
- early detection of breast and cervical cancer;
- improved surveillance of the state cancer problem;
- access to state-of-the-art diagnosis and treatment;
- modification of dietary risk factors;¹²
- control of occupational and environmental carcinogen exposure.

Primary prevention. The Council is working with national organizations such as the American Lung Association, state professional groups, local medical centers, and health departments to reduce tobacco use. Its plan expands current anti-smoking efforts to all state-funded maternity, WIC, and family planning clinics, and it empowers communities to plan and implement targeted programs (e.g., bans or restrictions on tobacco use by students, staff, and visitors at schools; anti-tobacco media campaigns). The Council also promotes legislative efforts to increase excise taxes on cigarettes and mandate smoke-free public areas and work sites.

To modify dietary risk factors and increase the number of health professionals who offer nutrition counseling, the Council will improve statewide nutrition training. Another statewide plan targeting high risk groups will incorporate a nutrition component applicable to all major chronic diseases and associated risk factors.

Secondary prevention. The Council supports specific secondary prevention programs directed at breast and cervical cancer. The hospital-based and CDC programs are working with local health departments to increase the utilization of cancer screening and treatment through patient advocates, support groups, and improved notification procedures. The plan also promotes universal accreditation of low-dose, high quality mammography; standardized reporting terminology; and improved reimbursement for these services. To encourage Pap tests among low-income women, lists of physicians willing to treat indigent women and new sources of funding will continue to be developed.

The Maryland Cancer Registry is the central component of the Council's effort to create a surveillance system. To ensure complete case ascertainment, hospital reporting, recording of post mortem examinations, and cancer cases in Maryland residents detected in other regions will be included. Data will be analyzed and published annually to characterize risk factors, cancer clusters, and trends in Maryland. State data will be compared to national trends.

The cancer control plan is also designed to improve access to state-of-the-art diagnostic and treatment services within Maryland. The first priority is a survey of the standard of treatment for cancer in Maryland. The feasibility of alternate delivery systems, such as statewide triage and mandatory second opinions, is being explored. The Council is also

evaluating the impact of current reimbursement policies on access to oncology care among indigent persons and efforts are being made to improve subsidies for oncology care among the medically indigent.

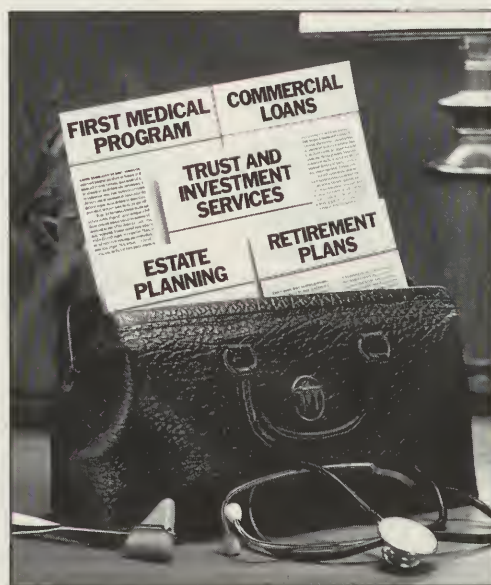
References

1. *Cancer Facts and Figures-1993*. New York: American Cancer Society; 1993.
2. Boring CC, Squires TS, Tong T, Montgomery S. Cancer statistics, 1994. *CA Cancer J Clin* 1994;44:27-42.
3. *Maryland Cancer Control Plan*. Baltimore, MD: Maryland Cancer Consortium; January, 1991.
4. Miller BA, Gloeckler Ries LA, Hankey BF, Kosary CL, Edwards BK, ed. *Cancer Statistics Review: 1973-1989*. Bethesda, MD: National Cancer Institute; 1992 (NIH Pub. 92-2789).
5. Doll R, Peto R. The causes of cancer: quantitative estimates of avoidable cancer in the United States today. *J Natl Cancer Inst* 1981;66:1191-1265.
6. Epstein SS. Losing the war against cancer: who's to blame and what to do about it. *Int J Health Serv* 1990;20:53-71.
7. Davis DL, Hoel DG. Figuring out cancer. *Int J Health Serv* 1992;22:447-453.
8. Md. Ann. Code, Art. 48A, §477JJ (1991).
9. Md. Ann. Code, Art. 48A, §354JJ (1991).
10. Holleb AI. Cancer and poverty: a double tragedy. *CA Cancer J Clin* 1989;39:261-265.
11. Henderson BE, Ross RK, Pike MC. Toward the primary prevention of cancer. *Science* 1991;254:1131-1138.
12. Willett WC. Relation of meat, fat, and fiber intake to the risk of colon cancer in a prospective study among women. *N Engl J Med* 1990;323:1664-1672.

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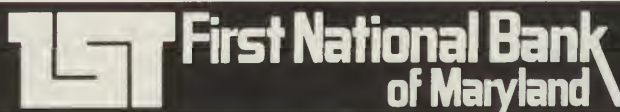


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Correlation of DNA flow cytometry and hormone receptors with axillary lymph node status in patients with carcinoma of the breast

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ABSTRACT: Axillary lymph node dissection (ALND) remains a standard staging procedure for patients with primary carcinoma of the breast. In a retrospective review of 63 patients with primary breast cancer who underwent ALND, statistical analysis showed that only tumor size was correlated with axillary lymph node involvement. Neither hormone receptor status, ploidy, nor percent S-phase contributed more to prediction of nodal size. Statistical analysis also indicated a significant correlation between receptor-negative status and the presence of positive axillary lymph nodes.

In women with breast cancer, axillary lymph node status remains the strongest predictor of a patient's risk of developing subsequent metastatic disease.¹ Axillary lymph node dissection (ALND), therefore, remains an important, if not the most important, staging procedure for breast cancer.² Although some investigators claim that surgical clearance of axillary lymph nodes improves survival,³ most authorities disagree.⁴

Because axillary lymph nodes are positive in approximately 30% of patients with clinically negative axillae,^{5,6} nearly 70% of patients needlessly undergo the procedure. Although the complication rate is low, more than 50% of patients complain of dysesthesia,⁷ and approximately 3% to 10% develop some degree of lymphedema.⁸ It would therefore be helpful to find a surrogate marker, or set of markers, that predict which patients with nonpalpable axillary lymph nodes will in fact be pathologically node negative.

To evaluate the correlation of the commonly available prognostic markers (primary tumor size, hormone receptor status, DNA ploidy, and percent S-phase) with the incidence of pathologically positive axillary lymph nodes, a retrospective study was undertaken over a two-year period of patients undergoing breast biopsy at Sinai Hospital of Baltimore.

Methods

Patients. Sinai Hospital of Baltimore is a 466-bed teaching hospital and tertiary care referral center. Pathology records of specimens analyzed for estrogen/progesterone hormone receptors (ER/PR) and/or flow cytometry between January 1991 and January 1993 were reviewed. Of the 142 cases available for study, 107 patients underwent ALND and 3 had palpable lymph nodes, for a total of 110 patients. ER/PR assays were performed in all cases. DNA flow cytometry (Nichols Laboratory, San Juan Capistrano, CA) was requested in 86 specimens. Twelve specimens (14%) were considered inadequate for analysis due to insufficient material. Of the remaining 74 cases, 37 (50%) were diploid and 37 (50%) were aneuploid. The percent S-phase could not be determined due to inadequate material in six specimens and to overlapping populations in three specimens among the aneuploid tumors. Two diploid tumors also contained overlapping populations, thus precluding analysis. All four parameters—tumor size, ER/PR status, ploidy, and percent S-phase—were available in 63 patients (28 with aneuploid tumors and 35 with diploid tumors), who represented the final study set. ER/PR status was obtained biochemically in 53 cases (84%) and immunohistochemically in 10 cases (16%).

Statistical analyses. Univariate and multivariate analyses were carried out using CRUNCH statistical software. All data were assumed to arise from bivariate populations and therefore Pearson correlation coefficients (*R*, product moment coefficients) were calculated. Significance was considered present for $R > 0.35$ with $P < 0.05$.

Five patients with indeterminate tumor size (4 with T4 tumors and 1 with a multifocal T3 tumor) were excluded from the multivariate analysis. Four of these patients had positive lymph nodes. In addition, chi-square analysis was carried out for the variables of T stage (T1 and T2 vs T3 and T4), ploidy (aneuploid vs diploid), receptor status (receptor negative vs other), and percent S-phase (high vs low), comparing the node-positive to the node-negative patients. The T3 and T4 patients excluded from the multiple regression analysis were included in the chi-square analysis. The cut-off value between high and low percent S-phase was 6.7%. A tumor was considered ER/PR negative if both ER and PR were less than 3 fmol/mg protein or both ER and PR failed to stain with the immunohistochemical technique. A tumor was considered receptor positive if both ER and PR were greater than 10 fmol/mg protein or both stained greater than 10% immunohistochemically. All other combinations were considered receptor "intermediate."

Results

The incidence of positive lymph nodes for the total group of patients was 40%: 36% (10 of 28) in the aneuploid group and 43% (15 of 35) in the diploid group. The distribution of node status based on tumor size is shown in **Table 1**. The mean

Table 1. Tumor distribution by stage, ploidy, and node positivity

| No. of Patients | Stage | Aneuploid | Diploid | Node Positivity |
|-----------------|-------|-----------|---------|-----------------|
| 19 | T1 | 7 | 12 | 2 (10.5%) |
| 34 | T2 | 18 | 16 | 14 (41%) |
| 4 | T3 | 2 | 2 | 4 (100%) |
| 6 | T4 | 1 | 5 | 5 (83%) |
| total 63 | | 28 | 35 | 25 (40%) |

percent S-phase for the diploid specimens was $6.3\% \pm 4.7\%$; the mean for aneuploid specimens was $12.1\% \pm 6.1\%$. The difference was not significant. Univariate analysis of all the data, without distinction made as to ploidy, indicated little correlation between the size of the tumor and the ER value, PR value, ploidy, or percent S-phase. However, there was good correlation ($R=0.4$; $P=0.04$) between the size of the tumor and the number of positive nodes. For diploid specimens examined as a subset, univariate analysis also showed little correlation between tumor size and ER value, PR value, or percent S-phase. There was good correlation, however, between tumor size and the number of pathologically positive nodes ($R=0.5$; $P=0.004$). Multiple regression analysis confirmed the findings of univariate analysis: only tumor size was correlated with the number of pathologically involved lymph nodes ($P=0.04$). Chi-square analysis showed that, compared to T3 and T4 patients, there was a significant number of T1 and T2 patients among node-negative women ($P < 0.01$). There was also a significant correlation between receptor-negative tumors and node-positive patients ($P < 0.05$).

Discussion

Many surrogate markers have been used as putative prognostic indicators for patients with breast cancer. The markers usually are correlated with survival as a sign of their clinical benefit. Because the involvement of axillary lymph nodes by breast carcinoma has remained one of the strongest prognostic indicators in breast cancer, the current study examined the combination of the most readily available prognostic indicators to see if they could reliably predict lymph node status before surgery. Results indicate that tumor size and to a lesser extent receptor status correlate statistically with node involvement. The addition of ploidy and percent S-phase to tumor size and receptor status fails to improve the predictive value of these two determinants.

Whether ER/PR status correlates with survival has long been disputed. Although numerous studies have produced divergent conclusions, there is general agreement that estrogen/progesterone negative tumors are associated with an adverse outcome.⁹ DNA ploidy analysis and growth fraction of tumors have been studied for the past 10 years. As a prognostic

factor for survival, these measurements have not added additional information for patients with positive lymph nodes.¹⁰ Among node-negative patients, however, those with diploid, low percent S-phase tumors have fared better than those with aneuploid, high percent S-phase tumors.^{11,12} Although ploidy status and percent S-phase could be presumed to predict which patients with clinically negative axillary lymph nodes would be pathologically node positive, the current study and one recently published⁷ do not support that presumption.

Similar results were obtained in a recently published study involving a cohort of more than 6000 patients. In that study, tumor size was the most important predictor of nodal status; however, no combination of features, including receptor status, ploidy, and S-phase, could predict a less than 10% risk, or alternatively, a greater than 75% risk of axillary node involvement.¹³

Conclusion

Of the study factors examined, tumor size remains the most reliable predictor of axillary lymph node metastasis in patients with primary breast cancer. Neither ploidy, percent S-phase, nor receptor status contribute more to this predictive ability. Although chi-square analysis showed a correlation between node positivity and receptor-negative tumors, the finding was not borne out by multiple regression analysis. Neither ploidy nor percent S-phase contributed more to this predictive ability.

Other than using tumor size and receptor status alone, it remains difficult to predict which patients with clinically negative axillae will be pathologically node negative. Markers that have been described, but which require further investigation, include the Her 2 neu oncogene,¹⁴ cathepsin D,¹⁵ heat shock protein,¹⁶ the p53 oncogene,¹⁷ and angiogenesis.¹⁸ The number of copies of the Her 2 neu oncogene recently has been reported to correlate with the extent of axillary node involvement,¹⁹ but these results require further validation. In addition, further research is needed with noninvasive means of evaluating the axilla, such as lymphoscintigraphy using sensitive, breast cancer-specific antibodies. In a recently published study, positron emission tomography was useful in identifying malignant axillary lymph nodes preoperatively in women with primary breast cancer.²⁰ Although the study results require replication, they could have a significant impact on the management of breast cancer. Such approaches eventually may obviate the need for axillary lymph node dissection.

References

1. Harris JH, Hellman S, Henderson IC, Kinne DW. Primary treatment of breast cancer. In: *Breast Diseases*. 2nd ed. Philadelphia, PA: J.B. Lippincott; 1991:361.
2. Danforth DN, Findlay PA, McDonald HD, Lippman ME, Reichart CM, d'Angelo T, et al. Complete axillary lymph node dissection for stage I-II carcinoma of the breast. *J Clin Oncol* 1986;4:655-662.

3. Fentiman IS, Mauseel RE. The axilla: not a no-go zone. *Lancet* 1991;337:221-223.
4. Fisher B, Redmond D, Fisher ER, Bauer M, Wollmark N, Wickerham L, et al. Ten-year results of a randomized clinical trial comparing radical mastectomy and total mastectomy with or without radiation. *N Engl J Med* 1985;312:674-681.
5. Moffat FL, Senofsky GM, Davis K, Clark KC, Robinson DS, Ketcham AS. Axillary node dissection for early breast cancer. Some is good, but all is better. *J Surg Oncol* 1992;51:8-13.
6. Fisher ER, Sass R, Fisher B. Pathologic findings from the National Surgical Adjuvant Project for Breast Cancers (protocol no. 4). X. Discriminants for tenth year treatment failure. *Cancer* 1984;53(3 suppl):712-723.
7. Lin PP, Allison DC, Waistock J, Miller KD, Cooley WC, Friedman N, et al. Impact of axillary lymph node dissection on the therapy of breast cancer patients. *J Clin Oncol* 1993;11:1536-1544.
8. Sacre R. Modern thoughts on lymph nodes in breast cancer. *Seminars in Surgical Oncology* 1989;5:118-125.
9. McGuire WL, Tandon AT, Alfred DC, Chamness GC, Raudin PM, Clark GM. Prognosis and treatment decisions in patients with breast cancer without axillary node involvement. *Cancer* 1992;70 (suppl):1775-1781.
10. Witzig TE, Ingle JN, Schaid DJ, Wold LE, Berlow JF, Gonchoroff NF, et al. DNA ploidy and percent S-phase as prognostic factors in node-positive breast cancer. Results from patients enrolled in two prospective randomized trials. *J Clin Oncol* 1993;11:351-359.
11. Clark GM, Dressler LG, Owens MA, Pounds G, Oldaker T, McGuire WL. Prediction of relapse or survival in patients with node-negative breast cancer by DNA flow cytometry. *N Engl J Med* 1989;320:627-633.
12. Sigurdsson H, Baltetorp B, Borg A, Dalberg M, Ferno M, Killander D, et al. Indicators of prognosis in node-negative breast cancer. *N Engl J Med* 1990;332:1045-1053.
13. Ravdin PM, DeLaurentis M, Wenger CR, et al. Can prognostic factors be used to predict the nodal status of breast cancer patients? *Proceedings of the American Society of Clinical Oncology* 1994;13 (abstract 103).
14. Allred DC, Clark GM, Tandon AK, Molina R, Tormay DC, Osborne CK, et al. Her 2 neu in node-negative breast cancer: prognostic significance of overexpression influenced by presence of in situ carcinoma. *J Clin Oncol* 1992;10:599-605.
15. Tandon AK, Clark GM, Chamness GC, Chirgwin JM, McGuire WL. Cathepsin D and prognosis in breast cancer. *N Engl J Med* 1990;322:297-302.
16. Cioce DR, Clark GM, Tandon AK, Fuqua SA, Welch WJ, McGuire WL. Heat shock protein hsp70 in patients with axillary lymph node-negative breast cancer: prognostic implications. *J Natl Cancer Inst* 1993;85:570-574.
17. Allred DC, Clark GM, Elledge R, Fuqua SAW, Braun RW, Chamness GC, et al. Association of p53 protein expression with tumor cell proliferation rate and outcome in node-negative breast cancer. *J Natl Cancer Inst* 1993;85:200-206.
18. Weidner N, Folkmen J, Pozza F, Pierantino B, Allred EN, Moore DH, et al. Tumor angiogenesis: a new significant and independent prognostic indicator in early-stage breast cancer. *J Natl Cancer Inst* 1992;84:1875-1887.
19. Seshadri R, Firgaira FA, Horsfall DJ, McCaul K, Setlin V, Kitchen P. Clinical significance of HER-2/neu oncogene amplification in primary breast cancer. *J Clin Oncol* 1993;11:1936-1942.
20. Crowe JP, Adler LP, et al. Positron emission tomography and breast masses: comparison with clinical, mammographic and pathological findings. *Annals of Surgical Oncology* 1994;1:132-140. ■

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Case #27

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DIAGNOSIS: METASTATIC DISEASE TO THE PERI-AORTIC NODES

The computed tomography (CT) scan (figure 1) reveals no evidence of malignancy. After the I.V. administration of Oncoscint CR-OV®, both the nuclear medicine planar (figure 2) and coronal SPECT (figure 3) images demonstrate abnormal increased tracer uptake in the upper abdomen (arrows). Surgery confirmed metastatic disease in the lymph nodes. Treatment was then appropriately altered.

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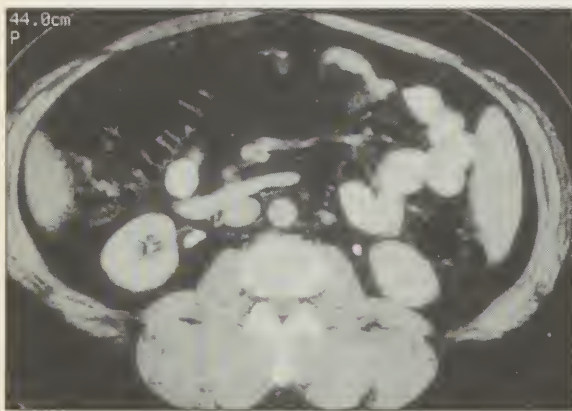


FIGURE 1

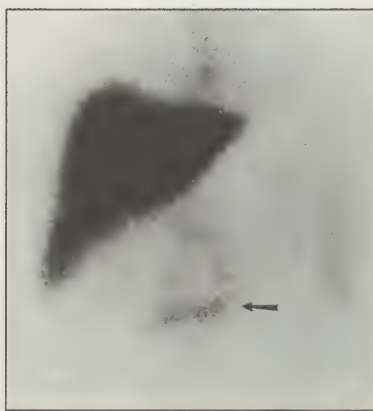


FIGURE 2



FIGURE 3

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Bilateral involvement of the cerebellopontine angles by malignant melanoma metastasis: a case report

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ABSTRACT: *Most tumors located at the cerebellopontine angle (CPA) are benign lesions, usually of neuroectodermal origin. This report describes a case of malignant melanoma with bilateral involvement of the CPA.*

Although malignant melanoma accounts for only about 1% of malignancies in the United States, it is the third most common tumor (after breast and bronchus) metastasizing to the central nervous system (CNS).¹ Clinically relevant CNS metastases have been reported to occur in 8%² to 46%¹ of patients. Male patients; patients with primary lesions of the head, neck, or oral mucosa; and patients with more invasive primary lesions have been shown to have higher incidences of CNS metastases.² Although leptomeningeal seeding occurs, the most common site of metastasis is intracerebral. There may be solitary or multiple lesions, typically located in either the gray matter or subcortically at the gray-white matter junction.³ Following is a description of rare bilateral involvement of the cerebellopontine angles (CPA) by metastatic melanoma.

Case report

A 67-year-old white man presented to his physician with a skin lesion in the lumbosacral region. The patient had first noticed the lesion approximately five years earlier. He decided to have it evaluated because of chronic irritation and occasional bleeding.

Physical examination showed a pale, white-to-pink skin lesion, 22 mm in diameter, with an irregular border and a central region of exophytic bleeding. There was no evidence of pigmentation. There were no other notable skin lesions and the patient had no palpable adenopathy. A punch biopsy showed a melanoma that had progressed to a depth of 2.7 mm (Clarke's Level IV).

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Figure 1. Non-enhanced T1-weighted axial magnetic resonance image at level L3-L4 shows recurrent tumor at the previous surgical site extending from the subcutaneous fat to the spinous process. Another tumor mass (arrows) is adjacent to the left lamina.



Figure 2. IV contrast enhanced axial computed tomography image of the posterior cranial fossa shows a faintly enhanced abnormal soft tissue mass filling the left porus acusticus region (arrow). No other discernible intra-parenchymal mass in the cerebellum is noted.

Computed tomographic (CT) scans of the chest, abdomen, and pelvis showed no evidence of metastatic disease.

The patient underwent wide local excision of the melanoma and a split-thickness skin graft from the adjacent left buttock. Surgical margins were negative for tumor. Ten months after excision, however, the patient returned with two separate subcutaneous masses (3 x 4 cm and 2 x 2 cm) at the superior and right lateral aspect of the skin graft site. Fine needle aspiration showed recurrent melanoma. Magnetic resonance imaging (MRI) of the region confirmed the palpable lesions with reticulation of the surrounding subcutaneous fat that extended to the level of the spinous processes of L3 and L4. There was also another mass adjacent to the left lamina (**Figure 1**). The patient underwent a second wide local excision with split-thickness skin graft taken from the right posterior thigh.

Four months after the re-excision, the patient noticed left-sided facial pain and weakness, left-sided hearing loss, and vertigo. CT scan of the brain showed a 3 mm enhancing lesion in the left temporal lobe, a 1.5 cm lytic lesion within the left temporal bone anterior to the mastoid, an equivocal 2 mm enhancing lesion within the medial aspect of the right temporal lobe, and small abnormal soft tissue filling the left porus acusticus (**Figure 2**). A cranial MRI with gadolinium showed enhancing masses involving the internal auditory canals bilaterally (**Figure 3**). Multiple small enhancing lesions 1 to 10 mm in diameter were distributed close to the surface of the brain in the sulci of both cerebral hemispheres. Tiny enhancing lesions were also noted adhering to the ventricular wall of the right occipital horn, adjacent to the anterior margin of the cerebral aqueduct, and close to the pineal gland (**Figure 4**). A comprehensive bone scan confirmed the left temporal lobe lesion, but did not show any other metastatic sites.

Discussion

Most CPA neoplasms are benign and usually of neuroectodermal origin. These tumors are most commonly acoustic neuromas, followed in frequency by meningiomas and epidermoid cysts.⁴ Metastatic lesions, however, are quite rare, representing only about 0.2% of all the tumors of the

CPA.⁵ The first documented case of metastatic disease to the CPA (from an oropharynx epithelioma) was reported by Cornil in the 1930s.⁶ Infrequent case reports have since documented other types of neoplasms that metastasize to the CPA. These include prolactinoma,⁷ lymphoma,⁸ lung and breast carcinoma,⁵ and adenocarcinoma of the colon.⁹ Malignant melanoma to the CPA was first described by Delerue in 1990.¹⁰

Metastatic neoplasms of the CPA are clinically distinct from benign tumors. Benign tumors are commonly slow growing and unilateral, becoming symptomatic only when they have reached a sufficient mass to cause nerve compression. Involvement of the closely approximated seventh (facial) and eighth (vestibulocochlear) cranial nerves results in weakness or facial paralysis, gustatory derangements, decreased salivary and mucosal gland function, vertigo, nausea, balance disorder, tinnitus, or hearing loss. Metastatic tumors, however, which can cause nerve dysfunction through direct cranial nerve invasion as well as through mass effect by surrounding edema, present in a more fulminant manner, despite their relatively small size. Auditory and vestibular symptoms may be bilateral and are rapidly progressive.

MRI characteristics also can help differentiate between benign and malignant lesions. The most common benign CPA tumor, acoustic neuroma, is typically unilateral and shows high signal intensity on T2-weighting. Symptomatic lesions are usually large enough to be readily visualized. By contrast, typical metastatic CPA lesions are small isointense lesions on T1- and T2-weighted images and often require contrast for proper visualization.⁴ Melanoma metastasis may appear isointense or hyperintense to normal white matter on T1-weighted images and hypointense to normal white matter on T2-weighted images, probably as a result of tumor hemorrhage.¹¹

In the case described here, the patient had recurrent melanoma with unusual bilateral CPA metastasis involving the seventh and eighth cranial nerves. The patient also had small metastases distributed close to the surface of the brain cortex, adhering to the ventricular wall of the right occipital horn, and adjacent to the anterior margin of the cerebral aqueduct. The primary lesion was at the midline lumbosacral region. The mechanism of

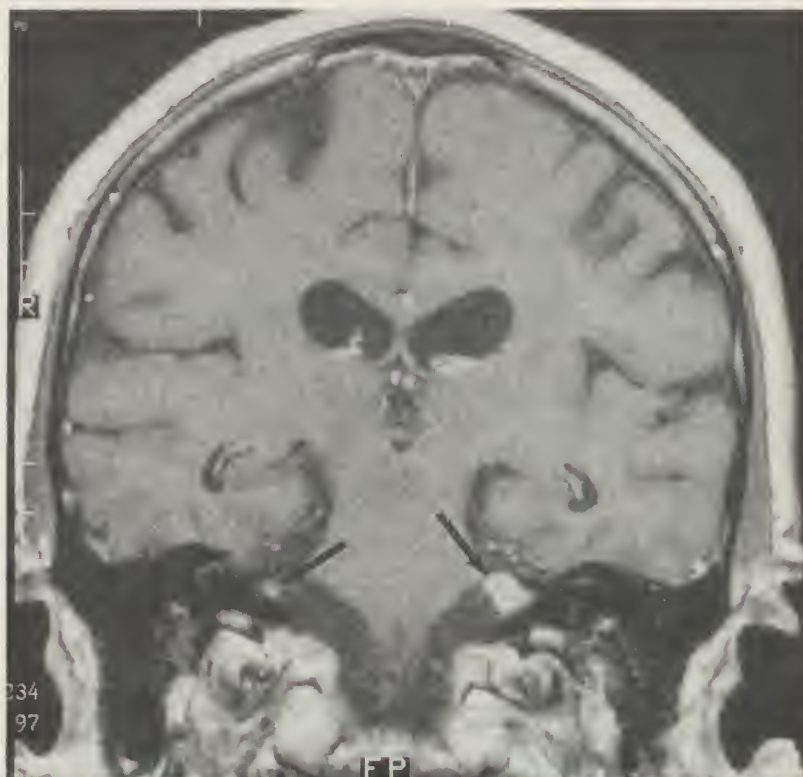


Figure 3. Post IV gadolinium-DTPA enhanced coronal T1-weighted magnetic resonance brain image depicts enhancing masses of different size in the region of both internal auditory canals (arrows).

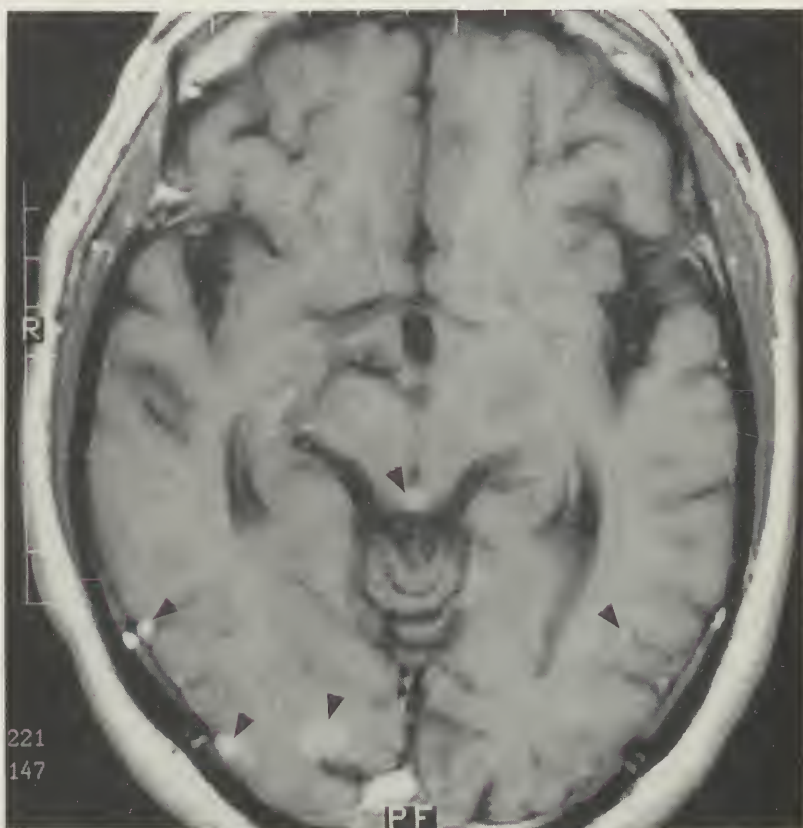


Figure 4. Multiple enhancing masses of various sizes deposited near the surface of the brain adjacent to the sulci and the cerebral aqueduct (arrowheads) are seen in this post IV gadolinium-DTPA enhanced axial T1-weighted magnetic resonance image.

spread in metastatic disease to the CPA may be through hematogenous seeding. In this case, however, given the location of the primary lesion and the distribution pattern of the metastases, another possible route of spread may be direct dissemination to the CNS through the cerebrospinal fluid.

References

1. Amer MH, Al-Sarraf M, Baker LH, Vaitkevicius VK. Malignant melanoma and central nervous system metastasis: incidence, diagnosis, treatment, and survival. *Cancer* 1978;42:660-668.
2. Bullard DE, Cox EB, Siegler HF. Central nervous system metastasis in malignant melanoma. *Neurosurgery* 1981;8:26-30.
3. Weisberg LA. Computerized tomographic findings in intracranial metastatic malignant melanoma. *Computerized Radiology* 1985;9:365-372.
4. Yuh WTC, Mayr-Yuh NA, Koci TM, Simon JH, Nelson KL, Zyroff J, Jinkins JR. Metastatic lesions involving the cerebellopontine angle. *AJNR Am J Neuroradiol* 1993;14:99-106.
5. Brackmann DE, Bartels LJ. Rare tumors of the cerebellopontine angle. *Otolaryngol Head Neck Surg* 1980;88:555-559.
6. Cornil L, Paillas JE, Vague J. Localisation pontocerebelleuse metastatique d'un epithelioma du cavum. *Rev Neurol (Paris)* 1934;67:106-111.
7. Cohen DL, Diengdoh JV, Thomas GT, Himsworth RL. An intracranial metastasis from a PRL secreting pituitary tumor. *Clin Endocrinol* 1983;18:259-264.
8. Nakada T, St John JN, Knight RT. Solitary metastasis of systemic malignant lymphoma to the cerebellopontine angle. *Neuroradiology* 1983;24:225-228.
9. Fischer A, Marres E, Thijssen H. A tumor in the cerebellopontine angle region: an unusual case. *Clin Neurol Neurosurg* 1977;80:189-194.
10. Delerue O, Destee A. Bilateral metastasis in the cerebellopontine angle. *J Neurol Neurosurg Psychiatry* 1990;54:562-563.
11. Woodruff W, Djang W, McLendon R, Heinz E, Voorhees D. Intracerebral malignant melanoma: high field-strength MR imaging. *Radiology* 1987;165:209-213. ■

Radiotherapy for cancer of the larynx: review of a community hospital experience

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ABSTRACT: Records of 106 patients with squamous cell carcinoma of the larynx treated with radiation therapy (RT) at Washington Adventist Hospital between 1976 and 1988 were analyzed for patterns of failure and survival, with a minimum of five-year follow-up. In patients treated with RT alone, initial local control rate was 72% for tumors involving supraglottic larynx and 90% for glottic larynx; in postoperative RT patients, the rate was 65% in the supraglottic and 67% in the glottic larynx group. The laryngeal preservation rate in patients treated with RT alone was 87% in those with early lesions (T1 and T2) and 63% in those with advanced tumors (T3 and T4). The overall five-year determinate survival rates of the RT-only group and the postoperative RT group were 90% and 57%, respectively. In patients with advanced tumors (stages III and IV), survival rates were comparable for RT alone and postoperative RT (56% and 52%, respectively).

The major goals in management of carcinoma of the larynx are controlling the primary tumors and regional lymph nodes and preserving the voice. Advances in radiation therapy (RT) have made it possible to cure a high percentage of less advanced tumors without sacrificing the voice. In early vocal cord cancers, the five-year cure rate with RT equals that obtained with surgery. In patients with advanced tumors, RT is associated with a higher incidence of recurrence; however, when radiation fails, laryngectomy offers a second chance for controlling the disease. In patients with very advanced tumors, the prognosis is poor, and the best results may be obtained with combined surgery and RT.¹ This article presents the results of a retrospective study of patients with laryngeal carcinoma treated in the department of

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Table 1. Tumor distribution by primary site and clinical stage

| Stage | Supraglottic | Glottic | Subglottic | Total |
|--------------|-----------------|-----------------|---------------|-------------------|
| I | 5 | 46 | 0 | 51 |
| II | 6 | 14 | 0 | 20 |
| III | 10 | 1 | 0 | 11 |
| IV | 20 | 2 | 2 | 24 |
| Total | 41 (39%) | 63 (59%) | 2 (2%) | 106 (100%) |

radiation oncology at Washington Adventist Hospital in Takoma Park, Maryland.

Methods

From January 1976 through June 1988, 109 patients with laryngeal cancer were treated in the department of radiation oncology at Washington Adventist Hospital. One had "oat cell" carcinoma and two received only palliative RT for lung metastases. The remaining 106 patients had histologic diagnoses of squamous cell carcinoma and were included in the retrospective analysis.

Of the 106 study patients, 93 (88%) were male, with the highest incidence in the 7th decade. The male/female ratio of supraglottic and glottic tumors was 5:1 and 13:1, respectively. Patients with supraglottic tumors ranged in age from 40 to 83 (average, 58); the age range in those with glottic tumors was 37 to 86 (average, 63).

All patients were evaluated initially with direct laryngoscopy and biopsy by an otorhinolaryngologist. In every case, an effort was made to locate the site of tumor origin. To aid in locating the site and to determine the extent of disease, soft tissue roentgenograms, tomograms, laryngograms, and (recently) computed tomography (CT) scans were performed. Tumors were staged retrospectively according to the TNM system.² In the few patients in whom the primary site could not be determined (e.g., those with large bulky lesions), the site that

most closely fitted clinical presentation was chosen.

There were 41 supraglottic, 63 glottic, and 2 subglottic tumors (Table 1). Among the supraglottic tumors, the epiglottis was the most common site of origin (50%) and the arytenoid was the rarest (3%). Supraglottic tumors were more advanced at the primary site (73% at stages T3 and T4) compared with glottic tumors (5% at stages T3 and T4). They also were associated with a higher incidence of cervical node metastases on admission (56% vs 2% for glottic tumors). The distribution of cervical node involvement by primary site and T-stage is shown in Table 2.

The most common complaint for which patients with supraglottic tumors sought medical attention was throat irritation and/or pain on swallowing (55%). Hoarseness was the most common complaint for patients having glottic (85%) and subglottic (100%) tumors. The mean duration of the symptoms was about five months. Almost all patients were smokers (99%) and most were drinkers (87%).

Treatment was carried out using a Picker Cobalt 60 unit or 6MV X-rays. Primary RT with a small field was used for early disease stages (46 glottic and 5 supraglottic stage I tumors; 13 stage II glottic tumors) and postoperative RT was used for more advanced lesions (1 glottic and 2 supraglottic stage II tumors; 1 glottic and 6 supraglottic stage III tumors; and 15 supraglottic, 1 glottic, and 2 subglottic stage IV tumors). RT alone was used for patients who either refused surgery, were poor operative risks, or had fixed unresectable lymph nodes or unresectable primary tumors (4 stage II, 4 stage III, and 5 stage IV supraglottic tumors; 1 stage IV glottic tumor).

For early lesions, RT involved the use of small (average, 5 x 5 cm) lateral opposing fields and/or 45° wedged pair with a tumor dose of 60 to 70 Gy delivered in 30 to 35 fractions over

6 to 7 weeks. Each patient was set up daily by a physician. The postoperative irradiation technique was similar in all patients: The larynx and upper neck were treated through opposing lateral fields. The daily dose rate to the midplane was 180 cGy. About 60 Gy was administered in 34 fractions over

Table 2. Cervical node involvement by primary site and T-stage

| Stage | Supraglottic | | | | Glottic | | | | Subglottic | | | |
|--------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| | N ₀ | N ₁ | N ₂ | N ₃ | N ₀ | N ₁ | N ₂ | N ₃ | N ₀ | N ₁ | N ₂ | N ₃ |
| T1 | 4 | 1 | 0 | 0 | 46 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| T2 | 6 | 2 | 1 | 1 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| T3 | 4 | 1 | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| T4 | 4 | 4 | 6 | 4 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 |
| Total | 18 | 8 | 10 | 5 | 62 | 1 | 0 | 0 | 1 | 0 | 0 | 1 |

7 weeks. The lower neck and supraclavicular area were treated through an anterior field with the patient supine; 45 Gy in 25 fractions was administered at a depth of 3 cm over 5 weeks. For advanced lesions treated with primary RT, the shrinking field technique was used for the final 20 to 25 Gy after 45 Gy was administered over 5 weeks to the primary and whole neck.

Local failures were recorded whenever the tumor was documented and determined by physical examination or biopsy. Distant metastases to lungs, bone, and brain were documented by radiograph, radionuclide scanning, and CT scan. Absolute (overall) and determinate (cause-specific) survival were calculated from the initial date of treatment. All patients were followed until death or for a minimum of five years from the date of the first treatment.

Results

Local recurrences above the clavicle occurred in 85% of patients within 2 years and in 100% within 5 years of treatment. Of the 78 patients who had primary RT, 11 (14%) developed local recurrences. Of these, 6 were salvaged by subsequent surgery, resulting in ultimate control in 94% (73 of 78).

Ultimate local control was achieved in 7 of 10 (70%) patients with advanced tumors (stages III and IV) treated by primary RT. Combined therapy resulted in ultimate local control for 16 of 25 (64%) patients with advanced tumors.

Table 3 shows the initial local control rate and surgical salvage rate by primary site, stage, and mode of therapy. Among patients receiving RT alone, the overall ultimate local control rate was 83% in those with supraglottic larynx tumors and 97% in those with glottic larynx tumors. Among patients in the postoperative RT group, the ultimate local control rate was 65% in the former and 67% in the latter. Local control was achieved in both patients with subglottic larynx tumors.

Table 3. Local control* after radiotherapy and surgical salvage

| Primary site | Stage | Radiotherapy alone | | | Postoperative radiotherapy | | |
|--------------|-------|--------------------|--------------|------------------|----------------------------|--------------|------------------|
| | | Initial control | No. salvaged | Ultimate control | Initial control | No. salvaged | Ultimate control |
| supraglottic | I | 5/5 | - | 5/5 | - | - | - |
| | II | 3/4 | 1/1 | 4/4 | 2/2 | - | 2/2 |
| | III | 3/4 | 0/1 | 3/4 | 4/6 | 0/2 | 4/6 |
| | IV | 2/5 | 1/2 | 3/5 | 9/15 | - | 9/15 |
| | | 13/18 (72%) | 2/4 | 15/18 (83%) | 15/23 (65%) | 0/2 | 15/23 (65%) |
| glottic | I | 43/46 | 2/3 | 45/46 | - | - | - |
| | II | 10/13 | 2/3 | 12/13 | 1/1 | - | 1/1 |
| | III | - | - | - | 1/1 | - | 1/1 |
| | IV | 1/1 | - | 1/1 | 0/1 | - | 0/1 |
| | | 54/60 (90%) | 4/6 | 58/60 (97%) | 2/3 | - | 2/3 |
| subglottic | IV | - | - | - | 2/2 | - | 2/2 |
| Total | | 67/78 (86%) | 6/10 | 73/78 (94%) | 19/28 (68%) | 0/2 | 19/28 (68%) |

*above clavicles

Among patients who received only RT, the five-year absolute and determinate survival rates were 80% and 90%, respectively. Among those who received postoperative RT, the rates were 46% and 57%, respectively (Table 4).

Table 4. Five-year survival

| Primary site | Stage | Absolute survival | | Determinate survival | |
|--------------|-------|-------------------|----------------|----------------------|----------------|
| | | RT alone | Post-op RT | RT alone | Post-op RT |
| supraglottic | I | 3/5 | - | 3/3 | - |
| | II | 3/4 | 1/2 | 3/3 | 1/1 |
| | III | 2/4 | 3/6 | 2/3 | 3/5 |
| | IV | 3/5 | 6/15 | 3/5 | 6/13 |
| | | 11/18 (61%) | 10/23 (44%) | 11/14 (79%) | 10/19 (53%) |
| glottic | I | 41/46 | - | 41/43 | - |
| | II | 10/13 | 1/1 | 10/11 | 1/1 |
| | III | - | 1/1 | - | 1/1 |
| | IV | 0/1 | 0/1 | 0/1 | 0/1 |
| | | 51/60 (85%) | 2/3 | 51/55 (93%) | 2/3 |
| subglottic | IV | - | 1/2 | - | 1/1 |
| Total | | 62/78 (80%) | 13/28 (46%) | 62/69 (90%) | 13/23 (57%) |

Table 5. Preservation of normal laryngeal function with radiotherapy alone

| Primary site | Stage | No. Patients | Failures* | Severe edema** | Laryngeal voice preserved |
|--------------|-------|--------------|-----------|----------------|---------------------------|
| supraglottic | T1 | 5 | 0 | 0 | 5/5 (100%) |
| | T2 | 6 | 2 | 1 | 3/6 (50%) |
| | T3 | 3 | 1 | 0 | 2/3 (67%) |
| | T4 | 4 | 2 | 0 | 2/4 (50%) |
| | | 18 | 5 | 1 | 12/18 (67%) |
| glottic | T1 | 46 | 3 | 0 | 43/46 (93%) |
| | T2 | 13 | 3 | 0 | 10/13 (77%) |
| | T3 | - | - | - | - |
| | T4 | 1 | 0 | 0 | 1/1 (100%) |
| | | 60 | 6 | 0 | 54/60 (90%) |

- * following initial radiotherapy
- ** necessitating tracheostomy

For patients with advanced carcinoma (stages III & IV) treated by primary RT, the determinate survival rate was 56%; in those treated with combined surgery and postoperative RT, it was 52%, although the primary RT group had more unfavorable conditions (e.g., older age, more intercurrent disease, and poor general condition).

Of a total of 106 patients, 7 (7%) developed distant metastases initially (3 in lung, 2 in bone, 1 in brain, 1 in liver). Second primary respiratory tract tumors (8 in lung, 4 in oropharynx, 2 in oral cavity, 1 in hypopharynx) occurred in 15 patients (14%).

Table 5 shows the incidence of laryngeal voice preservation by primary site and T-stage in patients treated with RT alone. Voice was preserved in 67% of supraglottic and 90% of glottic carcinomas. Of 8 patients with advanced stage tumors (T3 and T4), voice was preserved in 5 (63%); of those with early stage tumors (T1 and T2), it was preserved in 87%. Of 28 patients treated with combined surgery and RT, 2 (7%) had partial laryngectomy and retained their voices. Two patients (2%) developed severe edema in the larynx, one of whom required a tracheostomy. Both continued using alcohol and tobacco after completion of RT. There were no soft tissue necroses, including chondritis or myelitis.

Discussion

Management of cancer of the larynx presents a multifaceted challenge because of the unique role of the larynx in speech, swallowing, and respiration. Because treatment affects these critical functions, optimal treatment planning involves quality of life issues. There are two principal approaches to treatment. The first is primary surgery with or without adjuvant RT.^{1,3} The second is primary RT with surgery reserved for the treatment of persistent or recurrent disease.⁴⁻²¹ Lederman⁵ compared results from two hospitals at which physicians practiced ac-

cording to these different approaches. Results were similar in terms of five-year survival, but the advantage of initial RT was in the larger number of patients in whom surgical resection was avoided (372/487, 76%). Laryngectomy after radiation failure has resulted in an average five-year survival of 52% (227/439) in the series collected from the literature. On the other hand, RT for recurrence after surgery is rarely successful. Among 181 cases collected from the literature, only 19 patients (10%) survived five years.⁴

Although the role for chemotherapy in the treatment of laryngeal lesions has not been fully defined, clinical investigations have focused on the addition of chemotherapy to surgery and RT for local or regionally advanced disease in an attempt to reduce the need for surgical intervention and improve cure rates.

Pilot trials using induction chemotherapy suggest that surgery could be omitted without compromising survival in patients who respond to chemotherapy.^{23,24}

In 1985, a multi-institutional prospective randomized clinical trial was initiated to determine if a combination of cisplatin and fluorouracil induction chemotherapy and definitive RT could be an effective alternative to laryngectomy and postoperative RT in patients with operable stage III or IV laryngeal cancer. Results of this study of 332 patients with three-year follow-up indicate that sequential induction chemotherapy plus RT can achieve survival rates (53%) similar to those obtained by total laryngectomy and postoperative RT (56%), with preservation of the larynx in 64% of patients.²⁵ These results appear to be comparable to those reported in retrospective studies of primary RT.^{9-14,18,20} Thus, it is not clear if chemotherapy adds anything to conventional RT alone. Because the results of RT alone have not been directly compared with induction chemotherapy plus RT in similarly staged patients, the contribution of chemotherapy in those schema remains uncertain.

Conclusion

In the current study, treatment of stages I and II carcinoma by primary RT resulted in a high cure rate with retention of the larynx. Voice quality was uniformly excellent, although a few patients reported intermittent hoarseness associated with upper respiratory tract infections in the winter months. Patients with advanced carcinoma (stages III and IV) who were treated with primary RT had a relatively favorable prognosis. Ultimate local control was achieved in 70% and voice preserved in 63%, results that compare favorably with other reports in the literature.^{6-8,18-20} Among patients treated with combined surgery and RT in the current study, the ultimate local control rate was 61%,

but the voice was preserved in only 7% (2/28). These figures are also comparable to those reported by others.^{21,22}

The concept of using RT alone presumes equal survivorship and a low complication rate compared with laryngectomy. Although the cohort in the current study was too small to permit definite conclusions regarding individual stage groupings, it appears that a policy of using RT first and reserving surgery to salvage recurrences is not inferior to the alternative. Results from studies involving larger numbers of patients support this conclusion.^{4,21} The reported overall five-year survival rate ranges from 50% to 60%, with larynx preservation in 60% to 70% of patients with advanced tumors treated with primary RT.^{9-14,18,20}

The treatment approach for patients with early cancers should emphasize the reduction of treatment morbidity and prevention of second primary tumors. Management goals for patients with advanced disease should include improvement in the cure rate and improvement in the quality of life. Development of treatment approaches for organ preservation that achieve a survival rate similar to those achieved by laryngectomy is clearly an exciting step in that direction.

References

1. Kirchner JA, Owen JR. Five hundred cancers of the larynx and pyriform sinus. Results of treatment by radiation and surgery. *Laryngoscope* 1977;87:1288-1303.
2. American Joint Committee on Cancer. *Manual for Staging of Cancer*. Chicago, IL: J.B. Lippincott Company; 1992:39-41.
3. Ogura JH, Sessions DG, Spector GJ. Conservation surgery for epidermoid carcinoma of the supraglottic larynx. *Laryngoscope* 1975;85:1808-1815.
4. Vermund H. Role of radiotherapy in cancer of the larynx as related to the TNM system of staging. *Cancer* 1970;25:485-504.
5. Lederman M. Radiotherapy of cancer of the larynx. *J Laryngol Otol* 1970;84:867-896.
6. Mendenhall WM, Parsons JT, Stringer SP, Cassisi NJ, Million RR. T₁-T₂ vocal cord carcinoma: a basis for comparing the results of radiotherapy and surgery. *Head Neck Surg* 1988;10:373-377.
7. Stewart JG, Brown JR, Palmer MK, Cooper A. The management of glottic carcinoma by primary irradiation with surgery in reserve. *Laryngoscope* 1975;85:1477-1484.
8. Wang CC, Montgomery WW. Deciding on optimal management of supraglottic carcinoma. *Oncology (Huntingt)* 1991;5:41-46.
9. Goepfert H, Jesse RH, Fletcher GH, Hamberger A. Optimal treatment for the technically resectable squamous cell carcinoma of the supraglottic larynx. *Laryngoscope* 1975;85:14-32.
10. Harwood AR, Bryce DP, Rider WD. Management of T₃ glottic cancer. *Arch Otolaryngol* 1980;106:697-699.
11. Harwood AE, Bealer FA, Cummings BJ, Keane TJ, Payne DG, Rider WD, et al. Supraglottic laryngeal carcinoma: an analysis of dose-time-volume factors in 410 patients. *Int J Radiat Oncol Biol Phys* 1983;9:311-319.
12. Croll GA, Gerritsen GJ, Tiwari RM, Snow GB. Primary radiotherapy with surgery in reserve for advanced laryngeal

carcinoma: results and complications. *Eur J Surg Oncol* 1989;15:350-356.

13. Harwood AR, Hawkins NV, Beale FA, Rider WD, Bryce DP. Management of advanced glottic cancer. A 10 year review of the Toronto experience. *Int J Radiat Oncol Biol Phys* 1979;5:899-904.
14. Lustig RA, MacLean CJ, Hanks GE, Kramer S. The patterns of care outcome studies: results of the national practice in carcinoma of the larynx. *Int J Radiat Oncol Biol Phys* 1984;10:2357-2362.
15. Maipong T, Razack MS, Sako K, Chen TY. Surgical salvage for recurrent "early" glottic cancers. *J Surg Oncol* 1989;40:32-33.
16. Meridith AP, Randall CJ, Shaw HJ. Advanced laryngeal cancer: a management perspective. *J Laryngol Otol* 1987;101:1040-1054.
17. Viani L, Stell PM, Dalby JE. Recurrence after radiotherapy for glottic carcinoma. *Cancer* 1991;67:577-584.
18. Chung CK, Stryker JA, Strauss M, et al. Radiotherapy in managing laryngeal carcinoma. *Pennsylvania Medicine* 1981;84:44-48.
19. Chung CK, Stryker JA, Abt AB, Cunningham DE, Strauss M, Connor GH. Histologic grading in clinical evaluation of laryngeal carcinoma. *Arch Otolaryngol* 1980;106:623-624.
20. Million RR. The larynx . . . so to speak: everything I wanted to know about laryngeal cancer I learned in the last 32 years. *Int J Radiat Oncol Biol Phys* 1992;23:691-704.
21. Fletcher GH, Jesse RH, Lindberg RD, Koons CR. The place of radiotherapy in the management of squamous cell carcinoma of supraglottic larynx. *AJR Am J Roentgenol* 1970;108:19-26.
22. Pfister DG, Strong E, Harrison L, Haines IE, Pfister DA, Sessions R, et al. Larynx preservation with combined chemotherapy and radiation therapy in advanced but resectable head and neck cancer. *J Clin Oncol* 1991;9:850-859.
23. Karp DD, Vaughan CW, Carter R, Willett B, Heeren T, Calareso P, et al. Larynx preservation using induction chemotherapy plus radiation therapy as an alternative to laryngectomy in advanced head and neck cancer. A long-term follow-up report. *Am J Clin Oncol* 1991;14:273-279.
24. Department of Veterans Affairs Laryngeal Cancer Study Group. Induction chemotherapy plus radiation compared with surgery plus radiation in patients with advanced laryngeal cancer. *N Engl J Med* 1991;324:1685-1690.
25. Snow JB, Kramer S, Marcial VA. Evaluation of randomized pre-operative and post-operative radiation therapy for supraglottic carcinoma. *Ann Otol Rhinol Laryngol* 1978;87:686-691.

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Neutropenia and fever in patients receiving chemotherapy in a community teaching hospital: results of a retrospective chart review

M. Obadina, M.D., C. Cho, M.D., A. Oketunji, M.D., W. Waterfield, M.D.

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ABSTRACT: *A retrospective chart review study of factors that may influence the outcome of cancer patients hospitalized with febrile neutropenia indicates that positive microbial cultures, older age, and hematologic malignancies may be associated with poor outcome (death during the hospitalization). The absolute neutrophil count was statistically significant only in patients with positive cultures. Good outcome was associated with negative microbial cultures and shorter length of hospital stay.)*

Neutropenia is a common complication of chemotherapy in patients with cancer.¹⁻³ Infection, however, may be difficult to document in the febrile neutropenic patient. In approximately 40% of such patients, although microbial culture results are negative,⁴ treatment with broad spectrum antibiotics results in clinical improvement, suggesting that the fever is due to an occult microbial source. The empirical use of antibiotic therapy has therefore become standard medical practice for patients with febrile neutropenia.

Several studies have compared antibiotic monotherapy with combination therapy.⁵⁻¹³ The present study, a retrospective chart review, was undertaken to document the microbial spectrum and identify factors that influence the outcome of patients with febrile neutropenia.

Patients and methods

The medical records of patients admitted to the St. Agnes Hospital oncology service between January 1988 and January 1992 were identified (N = 400). Of these, records of patients who had a diagnosis of neutropenia (absolute neutrophil count < 1000/cu mm³) and simultaneous fever (oral temperature > 101° F) were selected and the following data were abstracted:

Table 1. Types of malignancy

| | |
|---|---------------|
| solid tumors | 54 |
| adenocarcinoma | 1 |
| bladder | 1 |
| breast | 20 |
| esophagus | 1 |
| lung + breast | 1 |
| lung | 25 |
| pancreas | 1 |
| prostate | 1 |
| renal | 2 |
| sarcoma | 1 |
| hematologic malignancies | 19 |
| Hodgkin's lymphoma | 3 |
| leukemia | 2 |
| multiple myeloma | 2 |
| mycosis fungoides | 1 |
| non-Hodgkin's lymphoma | 11 |

age; type of malignancy; absolute neutrophil count (ANC); results of blood, urine, sputum, and triple lumen catheter tip culture; type of antibiotic therapy; duration of hospital stay; and eventual outcome. Good outcome was defined as discharge from the hospital; poor outcome was defined as death during the same hospital admission. A total of 100 admissions among 73 patients were included in the study.

Results

Patients' ages ranged from 23 to 88 (mean, 61.47; SD, 13.81). Nineteen patients had hematologic malignancies and

54 had solid tumors (Table 1). The median ANC was 256 cells/cu mm (range, 0 to 1000). In 32 patients, there were 41 positive cultures. The average duration of hospital stay was 14 days (range, 2 to 17 days). Of the 100 reviewed admissions, 78 (78%) resulted in discharge from the hospital. Multivariate analysis indicated that patient outcomes were affected by several factors.

Age. Patients were divided into two groups based on age. Of the 56 admissions in patients aged 65 or younger, there were 48 good outcomes (85.7%). Of the 44 admissions in patients older than age 65, there were 30 good outcomes (68.2%).

Type of malignancy. Of the 77 admissions in patients with solid tumors, there were 64 good outcomes (83.1%). Of the 23 admissions in patients with hematologic tumors, there were 14 good outcomes (60.9%). The difference was statistically significant ($P < 0.024$).

Duration of hospital stay. The average hospitalization was 9.8 days for patients with good outcomes and 18.5 days for those with poor outcomes.

Culture results. Cultures were negative in 68 admissions and positive in 32. In patients with negative cultures, there were 65 good outcomes (95.6%), compared to only 13 good outcomes (40.6%) in patients with positive cultures. The difference was statistically significant ($P = 0.001$).

Specific organisms also were isolated from various cultures (Table 2). Both Gram-negative and Gram-positive organisms were isolated from blood, urine, sputum, throat, triple lumen catheter tips, and cerebrospinal fluid. Most of the positive cultures were from blood (18) and urine (14). Gram-negative bacteria were isolated in 65.8% of cultures; the most common organism, *Escherichia coli*, constituted 26.8% of all positive cultures. Gram-positive organisms included 29.2% of isolates; *Staphylococcus aureus* was isolated in 14.6% of cultures and two patients (5%) had positive fungal cultures.

Absolute neutrophil count. In patients with good outcomes, the average ANC was 294.7 cells/cu mm; in those with poor outcomes, it was 217 cells/cu mm (Table 3). The difference was not statistically significant. In multivariate analyses, however, the ANC was found to be significant ($P = 0.001$) in patients with positive cultures: 22 of the 32 patients with positive cultures had an ANC less than 200.

Antibiotics. Antibiotics were used in 95% of the patients. The 5% of patients not given antibiotics had negative cultures and good outcomes. In 64% of the episodes studied, patients were treated with two or more antibiotics, one of

Table 2. Types of organisms isolated

| Organism | total | blood | urine | TLC tip | wound |
|-----------------------------------|-----------|-----------|-----------|----------|----------|
| <i>Staphylococcus aureus</i> | 6 | 2 | 1 | 0 | 1 |
| <i>Escherichia coli</i> | 11 | 6 | 5 | 0 | 0 |
| group D <i>Enterococcus</i> | 6 | 1 | 3 | 2 | 0 |
| <i>Pseudomonas</i> | 3 | 1 | 2 | 0 | 0 |
| <i>Staphylococcus epidermidis</i> | 3 | 1 | 0 | 1 | 0 |
| <i>Klebsiella</i> | 3 | 1 | 1 | 0 | 1 |
| <i>pneumococcus</i> | 1 | 1 | 0 | 0 | 0 |
| <i>Branhamella</i> | 1 | 1 | 0 | 0 | 0 |
| viridans streptococci | 1 | 1 | 0 | 0 | 0 |
| <i>Bacteroides</i> | 1 | 1 | 0 | 0 | 0 |
| <i>Lactobacillus</i> | 1 | 0 | 1 | 0 | 0 |
| <i>Candida</i> | 2 | 0 | 1 | 1 | 0 |
| <i>Serratia</i> | 1 | 1 | 0 | 0 | 0 |
| <i>Proteus</i> | 1 | 1 | 0 | 0 | 0 |
| totals | 38 | 18 | 14 | 4 | 2 |

Table 3. Absolute neutrophil count and outcome

| neutrophil count | good outcome | poor outcome |
|------------------|--------------|--------------|
| 0 - 200 | 39 | 14 |
| 201 - 500 | 21 | 6 |
| 501 - 1000 | 19 | 2 |
| mean A.N.C | 294.7 | 217 |

which was an aminoglycoside (usually gentamicin). In 31% of the episodes studied, treatment was with one antibiotic (ceftazidime in 87% of patients). A variety of antibiotics was used, however, and no specific antibiotic regimen appeared to have an influence on patient outcomes.

Discussion

In the present study, factors that appeared to be associated with favorable outcomes in cancer patients hospitalized with episodes of fever and neutropenia included younger age, solid tumor, shorter hospitalization, and negative cultures. Patients younger than age 65 had better clinical outcomes than older patients. It is well documented that younger patients generally do better, possibly due to a lower incidence of comorbid conditions. Patients with solid tumors also had better clinical outcomes than patients with hematologic malignancies, probably because the latter tend to involve the bone marrow and immune function directly, leading to prolongation of the neutropenia and an associated increase in the number of positive cultures. Finally, patients with good outcomes had shorter hospitalizations and negative cultures. These patients may have had occult infections and recovered quickly as their ANC counts returned to normal. In a study of a short course of antibiotics in febrile neutropenic patients with negative cultures,¹⁴ illness courses were benign and mean duration of antibiotic therapy was four days.

Although some studies have shown that the presence and severity of infection is correlated with the degree of granulocytopenia,¹⁵⁻¹⁷ the ANC in the present study was not statistically significant. Patients with positive cultures had lower ANCs and even patients with very low ANCs and negative cultures had good outcomes.

Several studies have compared antibiotic monotherapy with combination therapy.^{1,5-12} Microbial cultures in the present study disclosed both Gram-positive and Gram-negative organisms, but no conclusions could be drawn regarding the efficacy of the various antibiotic regimens used; 95% of study patients were treated with broad-spectrum antibiotics, which is the standard of care for such patients.^{4,13,14}

Due to the retrospective nature of the study, cause of death was often difficult to ascertain. Although their neutrophil

counts had normalized prior to death, most study patients who died had progressive malignancies that were unresponsive to treatment.

Conclusion

In the current study, positive culture was the most important risk factor for poor outcome. A large percentage of study patients with good outcomes had negative cultures. Patients with occult infection (not clinically or microbiologically detectable) had short hospital stays after rapid response to antibiotics. Thus, earlier hospital discharge (after 48 hours) or even outpatient management with antibiotics may be feasible for younger patients if their cultures are negative and they have become afebrile. Recent data support the concept that such management may reduce health care costs in this group of patients.¹⁸

References

1. Rubin M, Hathron JW, Marshall D, Gress J, Steinberg SM. Gram-positive infections and the use of Vancomycin in 550 episodes of fever and neutropenia. *Ann Intern Med* 1988;108:30-35.
2. Al-Fawaz IM, Kambal AM, Al-Rabeeh AA, Al-Rasheed SA, Al-Eissa YA, Familusi JB. Septicemia in febrile neutropenic children with cancer in Saudi Arabia. *J Hosp Infect* 1991;18:307-312.
3. Karim M, Khan W, Farooqi B, Malik I. Bacterial isolates in neutropenic febrile patients. *Journal of the Pakistan Medical Association* 1991;41:35-37.
4. Schimpf SC. Overview of empiric antibiotic therapy for the febrile neutropenic patient. *Review of Infectious Diseases* 1985;7(suppl 4):S734-S740.
5. Anaissie EJ, Fainstein V, Bodey GP, Rolston K, Elting L, Kantarjian H, Cabanillas F, McCredie KB. Randomized trial of beta-lactam regimens in febrile neutropenic cancer patients. *Am J Med* 1988;84:581-589.
6. Mortimer J, Miller S, Black D, Kwok K, Kirby WM. Comparison of cefoparozone and mezlocillin with imipenam as therapy in febrile neutropenic cancer patients. *Am J Med* 1988;85:17-20.
7. Shenep JL. Combination and single-agent empirical antibacterial therapy for febrile cancer patients with neutropenia and mucositis. *National Cancer Institute Monographs* 1990;9:117-122.
8. Chan CC, Oppenheim BA, Anderson H, Swindell R, Scarffe JH. Randomized trial comparing ciprofloxacin plus netilmycin versus piperacillin plus netilmycin for empiric treatment of fever in neutropenic patients. *Antimicrob Agents Chemother* 1989;33:87-91.
9. Engvall PA, Stiernstedt GT, Gunther GC, Bjorkholm MJ. Trimethoprim-sulphamethoxazole plus imipenam/cilastatin as second empirical therapy in febrile neutropenic patients with hematological disorders. *J Chemother* 1992;4:99-106.
10. Rolston KV, Berkey P, Bodey GP, Anaissie EJ, Khardori NM, Joshi JH, Keating MJ, Holmes FA, Cabanillas FF, Elting L. A comparison of imipenam to ceftazidime with or without amikacin as empiric therapy in febrile neutropenic patients. *Arch Intern Med* 1992;152:283-291.

11. Menichetti F, Del Favero A, Bucaneve G, Aversa F, Fiorio M. Using teicoplanin for empiric therapy of febrile neutropenic patients with hematological malignancies. *Br J Haematol* 1990;76(suppl 2):45-48.
12. Bodey G, Reuben A, Elting L, Kantarjian H, Keating M, Hagemester F, Koller C, Velasquez W, Papadopoulos N. Comparison of two schedules of cefoperazone plus aztreonam in the treatment of neutropenic patients with fever. *European Journal of Clinical Microbiology and Infectious Disease* 1991;10:551-558.
13. Wade JC. Antibiotic therapy for the febrile granulocytopenic cancer patient: combination therapy versus monotherapy. *Review of Infectious Diseases* 1989;11(suppl 7):S1572-S1581.
14. Kaplan AH, Weber DJ, Davis L, Israel F, Wells RJ. Short courses of antibiotics in selected febrile neutropenic patients. *Am J Med Sci* 1991;302:353-354.
15. Talcott JA, Siegel RD, Finberg R, Goldman L. Risk assessment in cancer patients with fever and neutropenia: a prospective, two-center validation of a prediction rule. *J Clin Oncol* 1992;10:316-322.
16. Talcott JA, Finberg R, Mayer RJ, Goldman L. The medical course of cancer patients with fever and neutropenia: clinical identification of a low-risk subgroup at presentation. *Arch Intern Med* 1988;148:2561-2568.
17. Bodey GP, Buckley M, Sathe YS, Freireich EJ. Quantitative relationships between circulating leukocytes and infection in patients with acute leukemia. *Ann Intern Med* 1966;64:328-340.
18. Rolston K, Rubenstein E, Frisbee-Hume S. Outpatient treatment of febrile episodes in low-risk neutropenic patients. *Proceedings of the American Society of Clinical Oncology* 1993;12:436-439. ■

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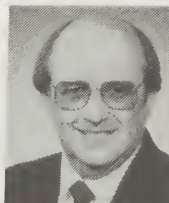
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Geriatrics for the Clinician

This is the inaugural column in a new series for Maryland Medical Journal readers. Geriatrics for the Clinician will bring you practical information regarding the care of one of the fastest-growing segments of our population—those over the age of 65. This age group accounts for more hospital admissions, consumes more medicines, fills more nursing home beds, and suffers more morbidity and mortality than any other age group. Our understanding of the problems of the elderly is improving daily, yet too few of these advances in geriatric medicine have found their way into the general medical literature. My goal as editor of this new column will be to deliver new information clearly. Approximately every other month, we will bring you up-to-date, pragmatic material that will improve your ability to care for your older patients. We will feature topics that are applicable across specialties, such as effective and safe drug prescribing, the concerns and health of caregivers to disabled elderly, nursing home care, and rehabilitation.

I look forward to bringing you this new column, and I welcome your comments and suggestions. Please send them to me in care of the managing editor. James P. Richardson, M.D.

Dr. Richardson is an associate professor in the department of family medicine at the University of Maryland School of Medicine. A graduate of the University of Maryland School of Medicine, he completed a residency in family medicine at the University of Maryland before serving in the National Health Service Corps in North Carolina. He holds a certificate of added qualifications in geriatric medicine.

IMMUNIZATIONS FOR THE ELDERLY

James P. Richardson, M.D., and Robert J. Michocki, Pharm.D.

Much attention has been given recently to the problem of poor immunization rates in children. Less well appreciated is the fact that elderly patients also are underimmunized, despite the availability of inexpensive, efficacious vaccines for influenza, pneumococcal disease, tetanus, and diphtheria.

Influenza, pneumococcal, and tetanus-diphtheria toxoid vaccines are recommended for all elderly. Following is a brief review of the indications for and use of these vaccines.

Influenza

Influenza accounted for more than 10,000 excess deaths in the United States during several different epidemics from 1977 to 1988; most of these deaths occurred among people aged 65 or older.¹ Influenza also increases hospitalization rates for pneumonia and other chronic conditions, yet less than 30% of high-risk individuals receive influenza vaccine each year.

Influenza vaccine is very effective. Immunization prevents clinical infection in at least 30% of elderly patients and reduces serious complications and death by at least 70%. Influenza vaccine also has been found to be up to 80% effective in protecting the elderly chronically ill population against hospitalization and death from acute respiratory disease during an influenza epidemic.²

Influenza vaccination is recommended for adults aged 65 or older. It is also recommended for nursing home residents, patients with chronic cardiac or pulmonary disease, patients with chronic metabolic diseases (e.g., diabetes mellitus, kidney failure), and immunosuppressed patients.¹ In the United States, vaccination should take place in October and November.

Influenza vaccine consists of purified, inactivated viruses grown in eggs and therefore it cannot cause influenza. The vaccine is very safe, but soreness at the injection site, fever, and malaise may occur and may last for a few days. Immediate

reactions such as hives or anaphylaxis are rare. The vaccine should not be administered to anyone with a history of hypersensitivity (allergy) to chicken eggs.

Influenza vaccination became a covered benefit for Medicare enrollees in 1993.

Pneumococcal disease

Streptococcus pneumoniae causes at least three serious clinical syndromes: pneumonia, meningitis, and bacteremia. Although deaths from these syndromes are estimated at 40,000 per year in the United States,³ as of 1985, less than 10% of those at high risk had been administered pneumococcal vaccine.

The pneumococcal vaccine that was first licensed in the United States in 1977 contained capsular polysaccharides to 14 of the serotypes thought to be responsible for the majority of disease. Since 1983, the vaccine has had capsular polysaccharides from the 23 serotypes that account for 88% of *S. pneumoniae* strains isolated from blood in the United States.⁴ Serious adverse effects of the vaccine are rare; severe systemic or allergic reactions occur in less than 1% of recipients.²

Physicians may have underutilized the pneumococcal vaccine in the past because studies of efficacy gave seemingly contradictory results. A recent case-control study, however, convincingly demonstrated an overall efficacy rate of 61% in immunocompetent adults.⁵ Efficacy in the well elderly also has been demonstrated in other studies.

One-time vaccination with pneumococcal vaccine is recommended for all healthy adults aged 65 or older. Nursing home residents should be vaccinated as well. The vaccine also should be given to patients with an underlying disease that increases susceptibility to pneumonia (see Table 1). Elderly patients at highest risk of serious pneumococcal disease (e.g., those with asplenia) may be considered for revaccination after six years. Patients who previously received

the 14-valent vaccine should be revaccinated with the 23-valent vaccine only if they are at the highest risk.² Pneumococcal vaccine can be given simultaneously (at separate sites) with influenza vaccine without causing a diminution in antibody responses nor an increase in adverse reactions.

In the United States, Medicare provides partial reimbursement for the cost of pneumococcal vaccine and its administration.

Tetanus and diphtheria

Although tetanus is much more rare than either influenza or pneumococcal disease, two thirds of tetanus cases in the United States occur in patients aged 50 or older. The case-fatality rate may exceed 50%. The elderly are at increased risk for tetanus because many never received primary immunization or because their immunity has waned.⁶ Similarly, although the incidence of diphtheria has decreased greatly, recent epidemics have occurred.

Primary immunization against tetanus and diphtheria is achieved with a series of three immunizations over six months. Immunity can be maintained by giving one injection of tetanus-diphtheria toxoid (Td) every 10 years.⁶ Patients with tetanus-prone wounds (such as puncture wounds) who have not completed a primary immunization series also

Table 1. Indications for pneumococcal vaccine in patients with increased susceptibility to pneumonia

- alcoholism
- asplenia
- chemotherapy
- chronic liver disease
- chronic lymphatic leukemia
- chronic pulmonary disease
- chronic renal failure
- diabetes mellitus
- heart disease
- Hodgkin's disease
- multiple myeloma
- organ transplantation

should receive human tetanus immunoglobulin. Patients with respiratory diphtheria should receive diphtheria antitoxin.

Td toxoid is a safe vaccine. The most common reactions to vaccination are mild pain and erythema at the injection site. Td toxoid should not be given to patients with a history of either a neurologic reaction or a severe hypersensitivity reaction following a previous dose. If patients do not recall tetanus immunization, a primary series of Td toxoid should be administered.

Conclusion

Immunizations for influenza, pneumococcal disease, tetanus, and diphtheria are effective, safe, and inexpensive. Knowledge of immunizations, however, is not enough to ensure their use. Physicians, hospitals, nursing homes, and other medical institutions should have systems in place to ensure proper immunization of their elderly patients. Such systems may be as simple as listing the dates of immunizations on the problem list, or as sophisticated as computer-generated reminders. Posting reminders in waiting rooms and asking nurses or medical assistants to track immunizations and remind providers and patients are other strategies that may be effective.⁷

References

1. Centers for Disease Control. Prevention and control of influenza: recommendations of the Immunization Practices Advisory Committee (ACIP). *MMWR Morb Mortal Wkly Rep* 1992;41:1-17.
2. ACP Task Force on Adult Immunization and Infectious Diseases Society of America. *Guide for Adult Immunization*. 2nd ed. Philadelphia, PA: American College of Physicians; 1990:78-83, 91-96, 110-113.
3. Fedson DS. Clinical practice and public policy for influenza and pneumococcal vaccination of the elderly. *Clin Geriatr Med* 1992;8:183-199.
4. Gardner P, Schaffner W. Immunization of adults. *N Engl J Med* 1993;328:1252-1258.
5. Shapiro ED, Berg AT, Austrian R, et al. The protective efficacy of polyvalent pneumococcal vaccine. *N Engl J Med* 1991;325:1453-1460.
6. Richardson JP, Knight AL. The prevention of tetanus in the elderly. *Arch Intern Med* 1991;151:1712-1717 (Erratum *Arch Intern Med* 1991;151:2451).
7. Richardson JP, Michocki RM. Removing barriers to vaccination use by older adults. *Drugs & Aging* 1994;4:357-365. ■

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I have an 18-month-old girl in my practice with breast development. She has had a 3 cm bilateral breast enlargement for about nine months and no other changes. Does she need any evaluation or treatment?

When evaluating a child with breast enlargement, it is important to assess the following. How long have the breasts been present? Are they increasing in size noticeably? Are there any other signs of sex hormone effect, specifically, pubic or axillary hair, axillary odor, vaginal discharge or bleeding, areolar thinning, acceleration of linear growth? Are there any abdominal masses on exam? Are there cafe-au-lait spots?

The differential diagnosis is premature thelarche vs precocious puberty. Premature thelarche is a benign, common condition that occurs most commonly in girls aged 6 months to 2 years. No other signs of puberty are present and the breast enlargement does not increase. A careful history and physical examination are necessary.

Initial evaluation usually includes a bone age determination, measurement of gonadotropin levels (luteinizing hormone [LH] and follicle-stimulating hormone [FSH]), and measurement of estradiol. If all levels are prepubertal, further work-up is unnecessary, but close follow-up must be ongoing.

If, at presentation, there are other signs of puberty or there is a history of rapid progression, then a complete work-up for precocious puberty is necessary. The first step is determining whether puberty is mediated by central gonadotropins (true or central precocious puberty) or is independent of pituitary gonadotropins. The differential diagnosis is done by measurement of LH and FSH and often requires a gonadotropin-releasing hormone (GnRH) infusion. Likely pathologies are idiopathic or central nervous system lesions (e.g., hydrocephalus, hamartomas, CNS tumors, and postinflammatory conditions). If central, CNS examination by magnetic resonance imaging is necessary. If the etiology is not central (prepubertal LH, FSH, and no response to GnRH), then a peripheral source of estrogens is present (e.g., ovarian cyst or tumor, adrenal tumor, exogenous estrogen exposure). If there is no clear history of an exogenous estrogen exposure, imaging of the ovaries and adrenals by ultrasound, computed tomography, or MRI is indicated. Cafe-au-lait spots indicate McCune-Albright syndrome, an unusual syndrome (due to continued activa-

tion of a membrane receptor protein) with three main features: precocious puberty, cafe-au-lait spots, and polyostotic fibrous dysplasia.

All children with precocious puberty should be referred to a pediatric endocrinologist. Premature thelarche, if definite, can be followed by a good general pediatrician.

LESLIE PLOTNICK, M.D.

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JAMES H. MERSEY
Editor

Suggested reading

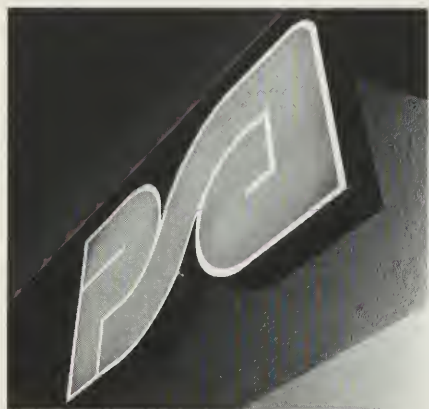
Plotnick LP. Puberty and gonadal disorders. In: Oski FA, DeAngelis CD, Feigin RD, Warshaw JB, ed. *Principles and Practice of Pediatrics*. Philadelphia, PA: J.B. Lippincott; 1994. ■

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Imaging Case of the Month

Pulmonary Lymphangitic Carcinomatosis from Adenocarcinoma of the Prostate

In 1987, a 72-year-old white man had a transurethral resection of the prostate for benign hypertrophy. A recurrence of bladder outlet obstruction six years later led to the discovery of a poorly differentiated adenocarcinoma of the gland, for which he received a course of radiation therapy. Nine months later, he was hospitalized for severe dyspnea, progressive muscular weakness, and bilateral edema of the lower extremities. Cough with the production of a colorless or white sputum had been present for several weeks.

Auscultation of the chest revealed scattered pulmonary wheezes. The heart sounds were distant, but a gallop, murmur, or rub were not present. The patient was believed to be in congestive heart failure.

A bilateral, diffuse, reticulonodular infiltrate and small pleural effusions were noted on the roentgenogram of the chest (Figures 1 and 2). Computed tomography of the chest disclosed accented interstitial markings, pleural effusions, and marked mediastinal lymphadenopathy. A similar examination of the abdomen disclosed a tumor conglomerate approximately 7 cm in diameter, mainly in the left retroperitoneal area. Multiple areas of focally increased technetium uptake on the bone scan, consistent with metastatic disease, were observed. The serum prostate-specific antigen (PSA) was elevated to 249 ng/ml. An echocardiogram demonstrated normal cardiac function. A transbronchial biopsy of the right lung showed deposits of metastatic adenocarcinoma in small lymphatics and thin-walled vessels. These cells took a positive stain for PSA and thus certified their prostatic origin.

The frequency with which metastatic carcinoma from any site will occur in the lung depends on the duration of the disease and the degree of effort expended to discover it. Lipschitz and North¹ have noted that on presentation, 5% of patients with carcinoma of the prostate will have pulmonary metastatic deposits of all types and that this figure will increase to 35% to 53% at autopsy. Being unusual in occurrence, the incidence of lymphangitic spread will be much lower. Munk and colleagues² did not find the prostate represented in their study of 21 patients with a specific diagnosis of pulmonary lymphangitic carcinomatosis.

The appearance of fine septal lines in the interstitium may represent the earliest detectable radiographic sign of lymphangitic carcinomatosis. Pleural effusions, sometimes bilateral, and hilar adenopathy also may be present. Such metastatic deposits are seen more commonly from malignancies of the breast, lung, and upper gastrointestinal tract because the lung contains the first microcirculatory bed encountered by metastatic cells from these tumors. By contrast, those new growths whose drainage is portal in nature will metastasize to the liver. Prostatic carcinoma is in an unusual position in relation to its passage to the lung. Bony metastasis from the pulmonary site apparently occurs before pulmonary growth is seen.

Pulmonary metastases will frequently go unrecognized inasmuch as they may occur as microscopic deposits in the paren-



Figure 1. Posterior-anterior roentgenogram of chest.



Figure 2. Right lateral roentgenogram of chest.

chyma or lymphatic vessels. Lymphatics are found in two areas: within the lung and in the pleura. Invasion of systemic veins at the site of origin probably accounts for most of the tumor emboli, although occasionally the lymphatic vessels are affected directly.

The importance of recognizing the presence of pulmonary lymphatic metastases is evident because when they are found, the prognosis in terms of life expectancy is poor. Certain manifestations may suggest the clinical diagnosis. Lymphangitic carcinomatosis has an insidious onset and may progress rapidly. Severe dyspnea and disability are noted within a short time, but evidence of cardiac failure is not present. Transbronchial biopsy may confirm the clinical impression.

References

1. Lipschitz HI, North LB. Pulmonary metastases. *Radiol Clin North Am* 1982;20:437-450.
2. Munk PL, Muller NL, Miller RB, Ostrow DN. Pulmonary lymphangitic carcinomatosis: CT and pathologic findings. *Radiology* 1988;166:705-709.

K. SCOTT MILLER, M.D., F.C.C.P., AND JOSEPH M. MILLER, M.D., F.A.C.S.

Dr. K. Scott Miller, an associate professor at the University of South Carolina School of Medicine in Charleston, is certified in internal medicine, chest diseases, and acute care. Dr. Joseph M. Miller is a retired surgeon from Timonium, Maryland. ■

Med Chi Bicentennial Celebrations

Med Chi has already begun planning celebration activities for its bicentennial in 1999. If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at 410-539-0872 or 1-800-492-1056.

PRACTICE ISSUES

A plan for medical liability reform. Position statement of the American Association of Neurological Surgeons, Congress of Neurological Surgeons, and Joint Council of the State Neurosurgical Societies.

Within the next few years, the federal government and state governments will enact extensive legislation that will affect health care payment reform.¹⁻⁵ The current system of medical malpractice litigation requires physicians to use all available resources to provide an acceptable standard of care, cost notwithstanding. Although this practice of defensive medicine may appear to provide each citizen with the ultimate in medical attention, in reality, medical expenditure to the "last dollar" is not beneficial when it leads to unnecessary tests and treatments; nor is it cost effective and affordable.⁶⁻¹²

Cost of defensive medicine

Seventy-eight percent of American physicians report that the threat of medical liability causes them to order far more diagnostic tests and procedures than are necessary to establish a diagnosis. A rough estimate is that two to two-and-a-half times more diagnostic studies are ordered than are required. Physicians participate in this practice simply to withstand the severe scrutiny anticipated under the current judicial system. The result has been the evolution of defensive medicine as the accepted and customary method of practice, thereby contributing to the spiraling cost of health care.²

The incidence of this cost-increasing practice is reportedly highest (87% or more) among hospital-based physicians, such as neurosurgeons.² The American Medical Association estimates that, in 1989 alone, physician costs for work over and above that which was necessary amounted to \$15.1 billion. Other studies suggest that for every dollar spent on physician medical malpractice insurance premiums, another \$3.50 is added in defensive medicine expenditures.^{8,11,13} By that formula, physicians, who spent \$5.6 billion on malpractice insurance premiums in 1989, would have generated \$19.6 billion that year in defensive spending, a figure that continues to grow each year as malpractice insurance premiums continue to rise. Both figures are conservative estimates that do not take into account expenditures for hospitalization, tests, and treatments.⁶

Approximately \$604.1 billion was spent on health care in 1989,¹⁴ of which approximately 18% (\$108.7 billion) was for physician fees. Using the conservative estimate of \$15.1 billion as the amount spent "defensively" by physicians in 1989, and projecting that it represents only 18% of the total defensive dollars spent that year, it is likely that an additional \$68.8 billion

was spent defensively to cover hospital, paraprofessional, procedural, and equipment costs. Thus, the estimated amount spent in 1989 for defensive reasons is \$88.9 billion—or 14% of total health care expenditures for that year (18% of \$83.9 billion equals \$15.1 billion). Some estimates place the cost as high as 30% of total health care costs, or \$181 billion.¹²

The exact percentage of defensive spending, however, is less important than what could be done with such huge sums of money. For example, \$83 billion could go a long way toward providing health care coverage for uninsured workers or for people below the poverty line who now are not eligible for Medicaid.⁷

In 1970, U.S. citizens spent approximately \$215 billion on health care—about 6% of the gross national product (GNP). By 1992, health care spending rose to an estimated \$820 billion—14% of the GNP.^{15,16} Although there are no studies to prove that liability reform would reduce defensive medicine expenditures, the potential savings are so great that the issue demands attention. A change in the current system of health care payment is clearly needed. However, physicians cannot be expected to cooperate unless simultaneous changes are made in the system for medical-injury payment.

Under the current system, 57% of all liability dollars are spent on the litigation process, leaving only 43% of insurance dollars available for injured parties.⁶ Administrative insurance costs subtract further from the available money.⁶ Driving the process is a system that allows malpractice attorneys to charge contingency fees of one third to one half of the amount awarded. No other nation in the world has a similar compensation arrangement. The incentive provided by large awards has created a very litigious society and an ever-increasing number of malpractice (and related) suits.¹⁷ Under the contingency fee system, most legitimate small claims are never filed because they generate insufficient legal fees. Thus, many true injuries go uncompensated.⁶

Fair and equitable resolution of all legitimate claims, with the bulk of any award going to the injured party, also requires changing the reasons for which malpractice claims are filed. Malpractice claims against physicians overwhelmingly fail to correspond with an identifiable *negligent* adverse event.^{14,15,17-19} Although "bad doctors" do exist, licensing, hospital review, medical society review, or state disciplinary committees should be responsible for their regulation—not the tort system.

High risk specialties and patient access to care

Although personal characteristics are poor indicators of the likelihood of an individual physician's being sued, practice specialty does correlate. Neurosurgery is among the highest risk

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branches of medicine,^{14,16,17,19} in part because, compared to other specialists, neurosurgeons manage conditions and perform procedures that have a higher probability of resulting in less-than-desirable outcomes. The association between the risk of a procedure and the risk of being sued also is supported by the fact that board-certified physicians experience more claims than their noncertified counterparts, probably because certified specialists take complicated cases that are more likely to be associated with “bad” outcomes.^{6,14}

Under the current system of defensive health care, many physicians are uncomfortable accepting patients who cannot afford the “last-dollar” defensive spending. Thus, patients with adequate financial resources and/or insurance coverage receive complete (even excessive) care while others must settle for less. When cost-conscious decision-making can safely replace defensive medicine, society will experience a dramatic reversal and very welcome change.

Cost as a defense

Under a new system in which cost control is a prime consideration, physicians will be subject to economic constraints in patient management, leading to the possibility of morally and ethically unfair decisions.^{20,21} Because of these constraints, physicians should not be held liable for every diagnostic and therapeutic decision. The unfair nature of such liability would have to be mitigated by allowing physicians to use an explicit, *cost-based* legal defense.^{20,21} The courts must recognize the need for, and allow, cost-conscious decision-making as a viable explanation for the occurrence of an untoward result. With careful design, cost-based defense could be introduced into the current tort system.²²

Shared contracts

Hospitals place a great deal of pressure on physicians to contain costs, yet share little in any liability that may be incurred. Therefore, it is reasonable to introduce policies that create shared tort liability contracts between doctors and hospitals. A proposal called *enterprise liability* would make hospitals financially responsible for all negligent injuries to inpatients. Such an arrangement already exists for hospitals owned and staffed by one entity, such as a university, county, or health maintenance organization.¹⁵ This approach has the advantage of promoting a team effort in containing the cost of daily patient care while continuing to deliver an acceptable level of quality.^{20,21} A common malpractice carrier could reduce the cost of any litigation by avoiding physician/hospital rebuttal in the court process. The dichotomy of the current malpractice situation, in which hospitals and physicians are often on opposing sides,

would be eliminated.²² Shared tort liability also would reduce the physician’s need to practice defensive medicine.

Another part of the shared tort liability concept could be contractual agreements between physicians and third-party payers. None of the government or private health insurance agencies currently shares any responsibility for medical malpractice claims filed over a cost-containment issue—a system that leaves treating physicians more vulnerable to malpractice actions for measures such as premature discharge from the hospital, reduction of hospital services, or withholding of diagnostic tests and expensive therapeutic measures. Under the proposed changes, third-party payers would be equally responsible for an injury that results from these types of cost-containment measures.²³ Again, the team effort would eliminate a dichotomy between physician and payer and could reduce the conflict over choosing between excessive care and cost containment.²⁴ Shared contracts also have the potential to reconcile the conflicting legal and economic incentives related to quality and ethics in the health care delivery process.²⁴ A major advantage of the shared liability concept is that it leaves the physician free to function as the patient’s advocate, with the payer and the hospital cooperating to control costs.²⁴

In recent years, consumers have been able to choose from a variety of managed health care delivery systems. Health care payment plans also could offer an additional choice: low-cost contractual agreements with a number of tort-rule options. For example, a reduced rate could be given to patients who waive the right to any future jury trial and choose instead to accept the results of binding arbitration (or an alternate system) in the resolution of any disputes.^{15,22} Patients also might agree to limit potential economic recoveries (caps) or they might accept a level of care that would take into account cost-conscious decision-making.

Some argue that such legally exculpatory agreements have no place in the practice of a learned profession²⁵ or that it is a disparity of bargaining power between physicians and patients that favors physicians.²⁶ However, if agreements are not imposed on patients under circumstances that might limit their opportunity to bargain for a different arrangement or the right to choose an alternative provider, courts should be receptive to the proposed changes.²⁷ Limitations applied to the shared contract approach can partially serve as a paradigm for ultimately resolving the conflict between cost containment and medical liability.²³

Accelerated compensation events

For many of these proposed changes to work, the public must understand and accept that not all “errors” in medical care are

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a result of negligence or substandard care. Although mistakes in professional judgment are often simply part of human imperfection, only physicians are currently expected to have perfect foresight. One proposed change would focus attention not on the *occurrence* of a "mistake" (negligent or otherwise), but on its *avoidability*. A compensation standard based on avoidability could bypass the need for a case-by-case determination of liability. Yet an unrestricted no-fault system would suddenly make a vast number of injuries eligible for compensation¹⁵. One solution would be to adopt a concept called the accelerated compensation event (ACE), which would establish an avoidability standard, irrespective of fault.¹⁵

If an injury falls within the legal definition of an ACE, it automatically would be compensated for on an administrative level, preferably according to an established schedule of damages.^{15,26} The classic prototype of an ACE is a surgical instrument or sponge unintentionally left in a patient during surgery.

Among the 11 ACEs thus far proposed, five are particularly applicable to neurosurgery: decubitus ulcer during inpatient care; complications due to air embolism during removal of an acoustic neuroma; postoperative displacement of an internal orthopedic device; complications due to thromboembolic disease; death other than with a high-risk patient.²⁶ They were proposed, however, with little or no understanding of neurosurgery: none necessarily deserves compensation automatically. Awards of this type could trigger a massive number of claims. For the concept to work, ACEs would have to be established by knowledgeable health care professionals and feasibility should be tested in a small-scale study in conjunction with an administrative-system demonstration project.¹⁵ Neurosurgical ACEs will be small in number and probably difficult to identify and establish.

Practice guidelines

Establishing practice guidelines also may help contain costs by reducing the number of unnecessary tests or treatments. Before full implementation, massive studies would be required on outcomes achieved for the resources spent. Without proper information, some practice guidelines could inadvertently reduce necessary, as well as unnecessary, services. Panels of academic and practicing experts representing patients, payers, malpractice carriers, hospitals, government agencies, and other groups should be established.¹⁵ Initial efforts to develop practice guidelines are appropriately being tried more in primary care settings than in subspecialties. Some guidelines being tried include those for acute pain management, low back problems, and screening for Alzheimer's and related dementias.¹⁵

Most neurosurgeons would agree that far too many magnetic resonance imaging and computed axial tomography scans and other expensive diagnostic tests are indiscriminately ordered before and after subspecialty consultation. Because responsibility often stops with subspecialists, however, they are forced by society and the necessities of defensive medicine to perform procedures that go beyond their perception of medical necessity.

Today's neurosurgeon, or any surgeon, is faced with a complex series of case management issues that cannot be governed by "cookbook" techniques. Any changes in the current system that require adherence to written standards must absolutely provide safe harbor from malpractice litigation when the pursuit of cost containment results in an undesirable outcome. Allowance also must be made for the development and application of new techniques.

Practice guidelines could work in subspecialties like neurosurgery if they are carefully and thoughtfully drawn up by neurosurgeons. Neurosurgical residency and continuing medical education programs already provide excellent guidelines for neurosurgical management referable to basic scientific knowledge, case individualization, and application of judgment. These principles seem preferable to rigid guidelines applied to the management of neurosurgical patients. Such guidelines and programs are already practiced in all branches of medicine and surgery.

Civil court system reform

Under the current tort system, compensation for legitimate claims is slow and the cost of litigation is greater than actual payments made to injured parties. Tort system reform at both federal and state levels could significantly reduce the number and size of malpractice claims. Coupled with alternative compensation methods and improved risk management approaches, tort system reform also could provide valuable societal benefits.^{6,13,15-17,22,28-30} The following changes are proposed:

- A cap on non-economic damage awards set at \$250,000, based on current economic standards.¹⁵
- Distribution of non-economic damages greater than \$100,000 over the duration of the expected need. If the injured party dies, payment should be discontinued.^{6,15}
- Reduction of liability awards by an amount equal to that paid to a plaintiff by collateral sources.¹³ This would include all benefits an individual receives or is entitled to receive under state or federal law, as well as those received from health insurance policies, wage continuation plans, or public disability insurance awards.¹⁵
- Elimination of the contingency fee system or adoption of the following sliding scale: 25% of the first \$100,000;

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20% of any amount between \$100,001 and \$200,000; 15% of any amount between \$200,001 and \$300,000; and 10% of any amount over \$300,001.⁶

- Replacement of joint-and-several liability by a comparative negligence rule. Except when a plaintiff can demonstrate that defendants acted in concert, each defendant should be responsible only for that portion of awarded damages that corresponds to his or her share of any fault.^{6,15}
- Allowing cost-containment decisions as a defense, provided one can prove that such measures were taken because of appropriate economic considerations and not out of negligence. Health care funding sources should combine the delivery of services with the acceptance of liability limitations based on cost-conscious decision-making.²⁰⁻²²
- Statutes of limitations running from the date of occurrence, not the date of discovery. For adults, the statute of limitations should not exceed two years from the date of occurrence except in cases of a retained foreign body. For neonatal injuries an appropriate limit would be six years from the time of occurrence, with age 8 being the latest at which an action could be brought.^{6,15}
- Abolition of punitive damages in medical liability cases or limitation to cases involving clear malice. The same \$250,000 cap should be in force, and awards should be paid to the state rather than the injured party.^{6,17} These damages should not be included when computing fees for attorneys.
- Requiring expert witnesses to meet acceptable criteria. For example, experts should actively practice within the specialty. They should not be allowed to accept a contingency fee, and fees for testifying should be reasonable. Testimony should be limited to scientific truth, and physician experts should not concern themselves with the legal issues of the case. They should thoroughly review the medical information available in a given case and should be required to identify statements that are personal opinions, not necessarily accepted as "truth" by other physicians within their specialty.²⁹
- Abolition of *addamnum* clauses, which specify the amount of damages sought. They encourage publicity, harm the defendant's reputation before any outcome has been decided, and distract the jury from the basic evidence being presented.¹⁷
- Adoption of the English rule whereby the losing side in any litigation, including attorneys, pays both parties' court costs and attorneys' fees. Defendants also should be allowed to countersue plaintiffs and their attorneys.^{15,17}

Risk management and quality assurance programs

Just as the legal profession must accept some changes, so must the medical profession. Professional state licensing and disciplinary boards must be structured to accept reports of physician incompetence. The following would aid in this effort:

- Require liability insurers to report the cancellation of any physician's malpractice insurance coverage.
- Require health care institutions to maintain credentialing and various quality-assurance committees, with periodic reviews, and to report any deviations from established standards to the state licensing board.
- Require licensing and disciplinary boards to conduct an on-site review of any physician whose conduct or credentials are being questioned and make a determination of that physician's ability to continue practicing medicine.
- Require all practicing physicians to attend continuing education programs and participate in safety and risk-management activities.^{6,15,24,28}

Alternative dispute resolution systems

To reduce health care costs, a fault-based administrative system could be established in each state with exclusive jurisdiction to decide all medical liability claims.²⁸ Under this proposal, a simplified procedure for filing health care negligence claims would be implemented and the administrative system would expedite the resolution of claims. To streamline the discovery process, each claim would be reviewed promptly by a judge and a panel of experts in the field chosen by the state medical faculty. The final step would be an expeditious formal hearing before an administrative law judge. An established appeals process would be included where necessary.^{15,24,28}

Although every individual has a right to a jury trial, it should be recognized that medical malpractice cases require expertise of a specific nature to differentiate between an adverse outcome due to negligent error(s) and one resulting from maloccurrence. Noncontrollable adverse events (such as might occur naturally during a serious disease) and non-negligent professional misjudgments are far more likely to be recognized by medical experts. Administrative systems that include an appeals process, but that bypass costly and lengthy jury trials, could simplify claims resolution and provide much swifter compensation for truly injured parties.^{15,24,28}

Defined injury compensation system

Under this fault-based system, state compensation funds are created for individuals who incur specific types of injuries while receiving health care services. A schedule of benefits is established for specific injuries, and a claimant could apply

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without legal counsel.¹⁵ State compensation funds (already operating in Nebraska and Indiana) also could provide coverage above that provided by baseline physician liability policies. These systems, funded by all health care professionals and institutions within the state, would place a cap on overall awards.

Binding arbitration

Under this proposal, patients could sign an arbitration agreement before receiving treatment. For the proposal to work, however, the state must establish the process as legally binding on all parties. Pretrial screening panels of professional and lay individuals also could operate in a similar manner. Claims would be reviewed for merit before trial or administrative resolution. Parties in litigation could then use the results in determining their pursuit of further action.^{6,15,28}

Conclusions

The United States is in the process of redefining its health care goals. At the center of this issue is the concern that health care costs are spiraling while insured medical coverage is unavailable to millions. To resolve this issue, priority must be given to processes and procedures that will contain health care costs and provide universal health care insurance. To reconcile inequities in the present system, reforms are needed in both the legal system and the health care payment system.

References

1. Angell M. The presidential candidates and health care reform. *N Eng J Med* 1992;327:800-801.
2. Brennan TA, Leape LL, Laird NM, Herbert L, Localio AR, Lawthers AG, et al. Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard medical practice study I. *N Eng J Med* 1991;324:370-376.
3. Davey LM. The hidden cost of malpractice. *Conn Med* 1990;54:209-211.
4. Physician Payment Review Commission. *Annual Report to Congress*. Washington, DC: Physician Payment Review; 1992.
5. Sloan FA, Mergenhausen PM, Burfield WB, Bovbjerg RR, Hassan M. Medical malpractice experience of physicians: predictable or haphazard? *JAMA* 1989;262:3291-3297.
6. AMA/Specialty Society Medical Liability Project. Chicago, IL: American Medical Association; 1992.
7. Danzon PM. *Medical Malpractice: Theory, Evidence and Public Policy*. Cambridge, MA: Harvard University Press; 1985.
8. Harris JE. Defensive medicine: it costs but does it work? *JAMA* 1987;257:2801-2802.
9. Howard JJ. Medical malpractice liability and cost containment. Law and economics in conflict. *Food Drug Cosmetic Law* 1988;43:309-334.
10. Morreim EH. Cost containment and the standard of medical care. *California Law Review* 1987;75:1719-1763.

11. Plager SJ, Sundall DN. *Report of the Task Force on Medical Liability and Malpractice*. Washington, DC: U.S. Department of Health and Human Services; 1987.
12. Tancredi LR, Bovbjerg RR. Rethinking responsibility for patient injury, accelerated-compensation events, a malpractice and quality reform ripe for a test. *Law Contemp Probe* 1991;54:147-177.
13. Reinhardt UE. Politics and the health care system. *N Eng J Med* 1992;327:809-811.
14. Reynolds RA, Rizzo JA, Gonzalez ML. The cost of medical professional liability. *JAMA* 1987;257:2776-2781.
15. *Olsen vs Malzen*. 558 SW 2d 429,430 (Tenn. 1979).
16. Robert Wood Johnson Foundation. Medical practice program: overview. *Abridge* 1991;1:1-8.
17. Blackett WB. Tort reform. Presented at the 42nd Congress of Neurological Surgeons, Washington, DC, October 31 to November 5, 1992.
18. Herz DA. Neurosurgical liability: the expert witness. *J Neurosurg* 1992;76:334-335.
19. Leape LL, Brennan TA, Laird NM, Lawthers AG, Localio AR, Barnes BA, et al. The nature of adverse events in hospitalized patients. Results of the Harvard medical practice study II. *N Eng J Med* 1991;324:377-384.
20. *Madden vs Kaiser Foundation Hospitals*. 17 Cal 3d 699, 552 P. 2d 178, 131, Cal Rptr 882, 1976.
21. Morreim EH. Commentary: stratified scarcity and unfair liability. *Case Western Law Review* 1986;36:1033-1057.
22. Clinton WJ. The Clinton health care plan. *N Eng J Med* 1992;327:804-807.
23. Kravitz RL, Rolph JE, McGuigan K. Malpractice claims data as a quality improvement tool. Epidemiology of error in four subspecialties. *JAMA* 1991;15:2087-2092.
24. *Tunki vs Regents of the University of California*. 60 Cal 2d 92 101,383 P. 2d 441,447,32 Cal Rptr, 33,39 (1963).
25. Northup GW. Defensive medicine: spiraling costs. *J Am Osteopath Assoc* 1987;87:545.
26. Socioeconomic Affairs Department. *Socioeconomic Factbook for Surgery, 1991-1992*. Chicago, IL: American College of Surgeons; 1991.
27. Localio AR, Lawthers AG, Brennan TA, Laird NM, Herbert L, Peterson LM, et al. Relation between malpractice claims and adverse events due to negligence. Results of the Harvard medical practice study III. *N Eng J Med* 1991;325:245-251.
28. AMA/Specialty Society Medical Liability Project. *Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System*. Chicago, IL: American Medical Association; 1988.
29. Hirsh HL. Defensive medicine: friend or foe? *Leg Med* 1989;1:145-180.
30. Wagner L. Defensive medicine: is legal protection the only motive. *Modern Health Care* 1990;20:41-42.

CHHABI BHUSHAN, M.B., B.S., L.M.C.C., F.A.C.S., AND DAVID A. HERZ, M.D.

Dr. Bhushan is an assistant professor of neurosurgery at Johns Hopkins Medical Center. Dr. Herz was chairperson of the medico-legal committee of the Joint Council of the State Neurosurgical Societies. ■

Reprints: Chhabji Bhushan, 1777 Reisterstown Road, Commerce Center East Suite 370, Baltimore, MD 21208.

PRACTICE ISSUES

New medical records copying charges effective October 1, 1994

Under a law passed by the Maryland General Assembly (now Chapter 585, Laws of Maryland 1994), effective October 1, 1994, physicians in Maryland may charge specific sums for preparation and production of medical records if they receive patient authorizations, subpoenas, or other proper legal requests for production.

The law authorizes the following charges:

- a preparation fee of no more than \$15, plus
- a fee of no more than 50 cents per page copied, plus
- the actual cost of postage and handling.

After July 1, 1995, these fees may be adjusted annually for inflation using the Consumer Price Index.

Physicians may demand payment of these fees and charges before turning the records over to a patient or other authorized person (such as the patient's parent, guardian or lawyer), but probably *not* before complying with a proper subpoena. Production may *not* be withheld under an emergency request from a state or local governmental unit concerning a child protective services or adult protective services case pending payment. Records also should not be withheld from another health practitioner pending payment of the copying fees. Finally, the law does not authorize any practitioner to withhold production of the medical records until fees for medical services themselves have been paid.

ANGUS R. EVERTON, ESQ.

Mr. Everton is general counsel for the Medical and Chirurgical Faculty of Maryland ■

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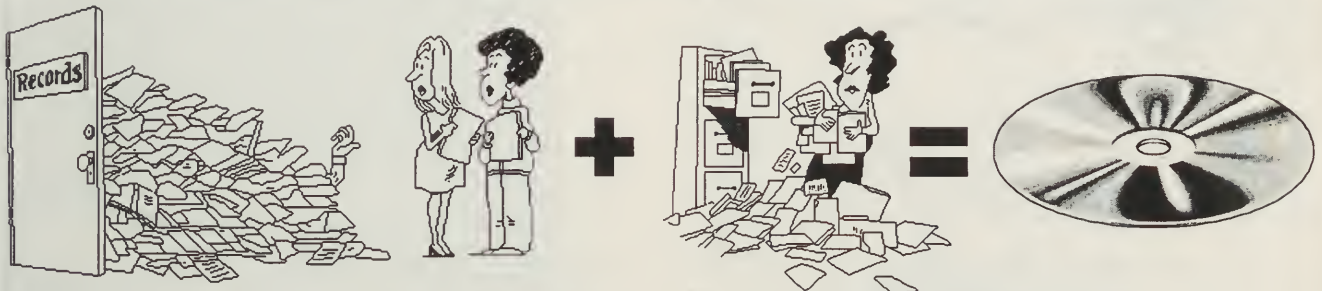


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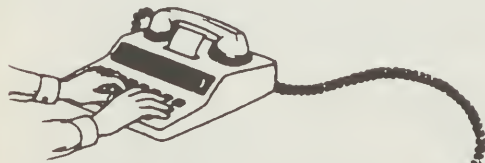
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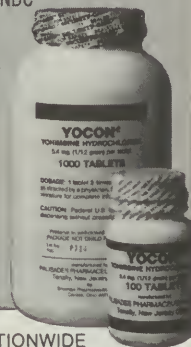
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Alliance

Ballard Senior Health Center

The Ballard Senior Health Center is, to our knowledge, the first medical alliance project of its kind in Maryland—perhaps in the nation. The concept originated with the Medical Society Alliance of Anne Arundel County, which recognized that health education would have the most positive impact on utilization of health services and on community relations.

Health education not only informs, guides, and prevents health problems, it also enhances the physician-patient relationship. We offer the opportunity for the physician to improve communication between the medical and senior citizen communities. Mutual respect and understanding are products of such communication. The senior citizen participants become more aware of how to improve mental and physical capabilities and are motivated to be active, enthusiastic partners in their health care. The Anne Arundel Alliance funds this worthwhile endeavor. The purpose of the health center is to

- provide a broad program of primary health guidance in a recreational and social environment;
- provide health education to the elderly, focusing on the prevention of health problems;
- and provide a link between the elderly and the recommended medical treatment by the medical community.

History

In November 1982, members of the Anne Arundel Alliance met with the director of the Office of Aging for the city of Annapolis regarding the possibility of opening a health center for the elderly in Anne Arundel County. The Annapolis housing authority offered a recreation building in a housing project for this purpose. In February 1983, a founding committee composed of Alliance members defined the center's purpose and outlined implementation of a program. The center was named for a respected spokesperson, Charles Ballard, who lobbied in the county and state legislatures and championed many causes in the senior community.

After initial plans were approved by the Anne Arundel County Medical Society in March 1983, the founding committee met with local hospital, city, and county representatives to assess available resources. An advisory board of community representatives and a board of directors, composed of Alliance members, were formed.

On April 21, 1983, the center opened to the public. Programs were offered each Friday morning from Sep-

tember through June. On March 30, 1984, the mayor of Annapolis dedicated the center on behalf of the Alliance to the senior citizens of Anne Arundel County in memory of Charles Ballard. Since the dedication, enrollment at the center has increased to well over 100 seniors, with 40 to 50 in attendance each Tuesday and Friday.

Current operations

The center conducts a three-times-per-week exercise program consisting of two days of low-impact aerobic exercise designed especially for seniors by Sally Linhardt. Line dancing is presented by Melvena Reese, a 79-year-old senior volunteer. The aerobics team has given demonstrations to local nursing homes, churches, and clubs. Moreover, the team has appeared on WBAL television.

The education program includes lectures, seminars, demonstrations, and screenings by local physicians and other health care professionals. In the past 12 years, we have covered the body from head to toe. We also have provided education on current medical issues and health care legislation.

After considerable research, we decided to present our health education programs with a theme. Last spring, our presentation was entitled "Positive Self-Image." Our fall theme is "Holistic Health." Medical problems usually are handled with either medication or surgery; however, alternatives to today's recognized health care methods are gaining wider acceptance. Our fall speakers will address issues such as healing and the mind; acupressure with massage techniques; Tai-Chi, yoga, and meditation; and biofeedback. The winter program, entitled "Understanding Pain," will address aching back, feet, stomach, head, joints, and . . .

The Medical Society Alliance of Anne Arundel County, through the Ballard Senior Health Center, has created a very intelligent group of medical consumers. We believe we have made a dramatic impact on the health habits of our local senior citizens, and we are pleased that through our efforts, they are living longer, healthier, and more fulfilling lives.

ELLENOR ALVAREZ AND CAROL FRIEND
Medical Society Alliance of Anne Arundel County

Ms. Alvarez is the director and Ms. Friend is the program coordinator of the Ballard Senior Health Center in Anne Arundel County, Maryland. ■

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Minutes of the Meeting of the House of Delegates
Friday, September 9, 1994

♦ *Members and guests present*

The list of members and guests present is available from the executive office of the Medical and Chirurgical Faculty of Maryland.

♦ *Call to order*

The meeting was called to order at 2:05 p.m. by the speaker of the house, Allan D. Jensen, M.D.

♦ *Invocation and National Anthem*

The speaker asked those present to stand for the invocation and National Anthem. Pastor Merle Fisher from the First Presbyterian Church in Ocean City delivered the invocation. Following the invocation, members remained standing for the playing of the Star Spangled Banner.

♦ *Report of Credentials Committee*

Daniel Kohn, M.D., co-chairperson of the Credentials Committee, reported a quorum was present.

♦ *Instruction to members*

The speaker noted that each delegate should state his/her name and component before speaking. It was also noted that Reference Committees A and B would meet on the following day starting at 9 a.m. to discuss the bylaws amendments, five-year resolutions, new resolutions, and the physician assistant report. The speaker asked members to have any amendments they wished to introduce in writing.

♦ *Introduction of members*

The following guests were introduced: W. Aubrey Godfrey, M.D., Medicare medical director, and Barbara Harvey, director, medical staff services, from Texas BlueCross BlueShield; Dennis Carroll, associate regional administrator for Medicare, Region III, Health Care Financing Administration; Richard E. Corlin, M.D., vice speaker, House of Delegates, American Medical Association, who would give a keynote speech the next day; and Paul Markowski, AMA field representative.

♦ *Approval of minutes*

The minutes of the July 21, 1994, meeting were approved as presented.

♦ *Media awards*

The speaker called on William Bruther, M.D., co-chairperson of the Public Relations Committee and one of the

judges for the media awards, to announce the media awards. It was noted that the winners' monetary awards would be donated to the charity of their choice.

Linell Smith was the first and second place winner in the daily newspaper category for her articles "Perimenopause" and "Survival Tactics," respectively, both of which appeared in *The Sun*. Ms. Smith asked that her award be given to the Chesapeake AIDS Foundation, Inc., a nonprofit organization that administers funds for HIV/AIDS assistance programs in Maryland.

Diane Brown won in the nondaily newspaper and magazine category for her article "The Painful Legacy of Agent Orange," which appeared in the *Columbia Flier*. Ms. Brown also won second place for her article "A Face in the Crowd: One in Eight Americans Experience Depression," which also appeared in the *Columbia Flier*. Dr. Bruther said Ms. Brown wanted her award donated to two organizations: the Chase-Brexton Clinic and the Leukemia Research Foundation Memorial Fund in memory of her brother, Jeffrey Bland. The house gave Ms. Brown a round of applause.

Honorable mention in the nondaily newspaper and magazine category went to Van Smith for his article "The Doctor is In: Schmoke Inches Toward His Medicalization Approach to Drug Reform," which appeared in the *City Paper*.

Dr. Bruther stated that the awarded articles were informative and should be read by all.

The winner in the radio category was John Stupak for his show *Sounds Like Addiction*, which was broadcast on the Consultation Radio Network. Mr. Stupak, who was unable to be present, had asked that his award be donated to the Alumni Scholarship Assistance Program of the Father Martin's Ashley Treatment Center. Dr. Bruther also recommended that everyone listen to the tape of this program, which was an interview with the conductor of a train that derailed and caused many deaths.

All media personnel and Med Chi's Public Relations Committee were thanked for their fine work with the media awards program.

The best 1993 *Maryland Medical Journal* article was "Have you come a long way, baby?" by Cynthia M. Lipsitz, M.D. Dr. Lipsitz was unable to be present to receive her award.

♦ *Emeritus membership*

The House approved the emeritus membership and waiver of dues as listed in the House of Delegates packet.

♦ *Report of the speaker of the house*

Allan D. Jensen, M.D., speaker of the house, reported that 143 members were present at the July 21, 1994, House of Delegates meeting and that it was successful. He said he was looking into concerns expressed by members regarding the shortage of time for debate. He also said that since the last House meeting, the specialty society section had been formed and that 19 specialty societies have qualified to have delegates to the House and 10 societies have submitted names of selected delegates. Beginning next spring, the specialty society section will select a member to the board of trustees.

Regarding reference committees, Dr. Jensen said that everyone was working toward more input into issues of importance to Med Chi. He said the reference committees would meet the next day at 9 a.m. to discuss the matters referred to them. He also said that the chairperson of Reference Committee A was Sheldon Bearman, M.D., and the chairperson of Reference Committee B was Howard Silby, M.D.

Dr. Jensen then said that at the last meeting, the matter of babysitting at the House meetings was brought up and that this was an important issue to many of the women members of Med Chi. He said that now and in the future, licensed babysitting services would be available to members and that the House agreed that this should not be a service funded by Med Chi. It was also noted that staff could not personally provide time for babysitting because of the concern regarding liability.

Dr. Jensen said one of the most important matters to be discussed at today's meeting was the budget. He said he appreciated all the hard work of Glen Burger, controller, and the Finance Committee for their input into the budget process. Dr. Jensen said important services are provided to members by Med Chi: peer review, legislative services, physician rehabilitation, etc.

Dr. Jensen then said that some members felt that the new bylaws passed at the 1994 annual meeting of Med Chi represented a mandate for change. He also said that if Med Chi members want all the services provided, there was a need for a dues increase, which has not been done in 15 years. He said it had been a mistake for the dues to not have been raised and that the dues should have been raised in small increments over this time. Dr. Jensen thanked the chief operating officer for assisting in the budgetary process.

Dr. Jensen concluded saying he looked forward to the members' participation in all the meetings during the semiannual meeting.

♦ *President's report*

The chairperson then called on Donald H. Dembo, M.D., president. Dr. Dembo said that this was a time for fellowship. He said dramatic changes have taken place during the four months following the passing of new bylaws at the annual meeting in May 1994. He said the major thrust and purpose of this change was to allow members to concentrate their energy in the pursuit of positive programs that would benefit the membership and the patients served by members. He then noted some Med Chi accomplishments:

- a \$200,000 grant from the Robert Wood Johnson Foundation to assist in Med Chi's efforts to achieve a smokefree Maryland;
- educational seminars on domestic violence being presented around the state;
- domestic violence program becoming a model nationally;
- gaining respect in the legislative arena;
- a successful health provider coalition;
- council and committee chairpersons and committee members dedicated to getting work done have been selected (Dr. Dembo said he achieved less geographic representation than he had desired);
- meetings with component presidents to address their concerns;
- meetings with council chairpersons to correlate and collate agendas;
- work of the preliminary IPA Committee completed;
- Maryland Physician Association, Inc., has been created and an interim board appointed, which is aggressively pursuing the creation of a multifunctional physician association.

Dr. Dembo said Med Chi is still marred by senseless political infighting and personal agenda. He said there are still major deeds to be accomplished and with the members' help they could be carried forth.

Regarding resolutions submitted to the board of trustees at the July 21, 1994, meeting, Dr. Dembo reported the following:

- 1-94: The Board of Trustees provided money in the budget to send a resident and student alternate delegate to their respective section meeting.
- 2-94: A motion was passed to require that nominees for Med Chi positions, including BPQA, submit a two-to three-page resume.
- 3-94: The back lot and the Meyerhoff parking lot will be used for delegates who attend House meetings at Med Chi. Med Chi is also looking into signing a contract to use another garage in the area.

- 7-94: The matter was referred to the Finance Committee.
- 12-94: Dr. Dembo said he had a dialogue with consultants about raising money to fund a managed care survey.

Dr. Dembo concluded by making a personal appeal to the members to consider a dues increase to assure Med Chi's ability to meet the demands made by its members.

♦ *CEO's report*

Angelo J. Troisi, F.A.C.H.E., chief executive officer, said he would be updating members on the operations of Med Chi:

- The name of Theodore Woodward, M.D., was submitted to the AMA as a nomination for the AMA Distinguished Physician Award.
- The names of Martin Wasserman, M.D., and Senator Patricia Sher were submitted to the AMA as nominees for the Nathan Davis Award.
- The front windows on the old faculty building were replaced.
- Awnings were placed over the back entrances of the faculty building and the Med Chi Agency building.
- A new copy machine from Xerox was purchased. Members of the AMA receive a 30% discount.
- The Annapolis Med Chi office is being renovated.
- Regional conferences have been scheduled and a needs assessment sent out to members in various geographic areas to ascertain what they would like to hear.
- The domestic violence seminar has been taken by over 250 health professionals.
- The OSHA seminar was attended by physicians and staff.
- An OSHA seminar was scheduled for October 19, 1994, at Doctors Hospital.
- Med Chi received good media coverage regarding the Robert Wood Johnson Foundation Smokeless States grant.
- There have been 85 new referrals to the physician rehabilitation program of Med Chi.
- There are 18 individuals receiving focused professional education.

Mr. Troisi concluded saying the handout prepared by his office included the names of federal legislators and numerous media articles on health care reform. He said it is important for each member to call his/her federal legislators to ask for updated health care reform information.

♦ *IPA update*

Dr. Jensen turned over the gavel to the vice speaker of the House, Louis C. Breschi, M.D. Dr. Breschi said that in the absence of the interim chairperson to the new IPA, Michael Epstein, M.D., Dr. Jensen would give the IPA report.

Dr. Jensen said a lawyer has been hired and Maryland Physicians, Inc., has been created. He noted the need to keep the organization under Med Chi and said it should serve as an umbrella group. Those wanting to join must be Med Chi members and \$1,000 application fee would be required. However, those who had already donated "seed" money to have the IPA set up would not have to submit this amount, but would be allowed a graduated fee based on the amount they had already given.

The IPA corporation would be run by an 11-member board that would not receive any compensation.

Dr. Breschi thanked Dr. Jensen for all he had done while serving as chairperson of the ad hoc committee that had proposed the corporation.

♦ *Committee reports*

Paul A. Stagg, M.D., secretary, presented the committee reports for 1993-1994. The reports appeared in the August issue of the *Maryland Medical Journal*. He said that all members were sent a list of the committee reports from this timeframe and that the list included the names of the chairpersons of those committees during that time. He said no action was needed regarding the information and that any action that had been needed was taken at the time the recommendation was originally presented to the governance body of Med Chi.

♦ *Report of council chairpersons*

Dr. Breschi said the only council chairperson reporting would be Joseph Fastow, M.D., who would report on Resolution 4-94. Dr. Fastow said he had received the resolution only recently after having assumed the chair of the Council on Medical Services and said that the resolution would be taken up by the TACs and a report given at the next House meeting.

♦ *Report of Med Chi Agency*

Ronald Fisher, director of agency operations for the Med Chi Agency, reported that the Med Chi Insurance Trust Fund was established in 1965 to offer association group insurance plans (disability, hospitalization and major medical, life and business overhead expense plan) to all Med Chi members. The Med Chi Agency was established in 1975 to broker medical malpractice insurance through the Medical

Mutual Liability Insurance Society of Maryland and is currently one of its largest brokers.

In 1989, Med Chi became a full service insurance operation encompassing services and products tailored for members: professional and business liability, workers compensation, personal insurance, health insurance, long-term care insurance, disability income protection, life insurance, retirement plans, and estate and financial planning. Mr. Fisher said that the agency's philosophy is to analyze the needs of and provide solutions for members rather than to sell products. Mr. Fisher said that members benefit also through the "non-dues income" from the agency. In 1993, Med Chi dues accounted for 32.2% of the monies spent for Med Chi services and the agency accounted for 19.5% of Med Chi's total revenue.

♦ *MMPAC report*

Frederick Hatem, M.D., chairperson of the Maryland Medical Political Action Committee (MMPAC), said that one third of the House of Delegates members were not MMPAC members. He said he felt that anyone in a leadership position should be a member of MMPAC because of the importance of the legislative process for physicians. He said MMPAC has been very active through the help of the lobbyist, Joseph Schwartz III, Esq., who provides solicited information about how much should be given to the various legislators and those in legislative positions. It was noted that contributions are made to best suit the needs of Med Chi.

Dr. Hatem said that MMPAC currently was being audited and that no audit had been performed since 1989. He said that in the past three months, three large groups of physicians had joined. He also said that although he understands the importance of members' belonging to their local PAC, it is important for them to belong to their state PAC because that is where the state legislative issues are handled. Dr. Hatem asked the members for their help regarding what contributions should be made on the local and state levels. He said it would make the job easier if input was received. In conclusion, he noted the importance of members' knowing their legislators.

♦ *Guest speakers*

Dr. Breschi turned the podium back to Dr. Jensen, who presented the guest speakers: W. Aubrey Godfrey, M.D., and Dennis Carroll.

Dr. Godfrey, Medicare medical director for BlueCross BlueShield of Texas, Inc., said it was an honor to be invited to speak at this state society meeting. He said that Barbara Harvey, director of medical staff services at BlueCross BlueShield of Texas, was present to help answer any ques-

tions. He said the greatest change that medicine has had is health system reform. He said it is not known what will come out of health system reform.

Dr. Godfrey also said that BlueCross BlueShield of Texas will do everything possible to have a smooth transition of Medicare Part B from Maryland BlueCross BlueShield to Texas BlueCross BlueShield. He said office space has been rented in Hunt Valley. He said the Texas group has formed a transition team and laid out a six-month transition period with timelines for over 1200 items to be met. The Texas group is very interested in working with Maryland physicians and expects to meet the guidelines set by the Health Care Financing Administration (HCFA).

Mr. Carroll, associate regional administrator for Medicare, Health Care Financing Administration, Region III, said there were three main reasons for his presence at the House meeting: to put a face on government; to inform the members of changes; and to learn from Med Chi members.

He said Maryland was in a transition period regarding Medicare Part B. He said Texas BlueCross BlueShield, trading as the Trailblazers, will take over the operation of Part B on January 1, 1995. He said it was Maryland BlueCross BlueShield's decision to no longer handle Part B. Mr. Carroll also said many of the Maryland employees have been offered positions with the Texas group. Thus, physicians who use Maryland Medicare Part B will be dealing with many of the same staff as they have in the past. Mr. Carroll emphasized the solid performance of the Texas group and said that this is Texas' second time to take over another system. During its prior experience with transition, changeover to the computer system was flawless.

Discussing Pennsylvania BlueCross BlueShield, which covers Montgomery and Prince George's County physicians, Mr. Carroll said that HCFA did find it deficient in several areas. He said the HCFA is asking for assistance from physicians to increase the numbers of Medicare individuals who receive the flu-shot vaccine (particularly African-Americans) and mammograms. He said HCFA has an obligation to see that everyone eligible to receive these medical services does receive them. He said HCFA will send an information package to Med Chi regarding these two concerns.

♦ *Question and answer session*

Henry Farkas, M.D., Cecil County, said the county health departments give out flu shots and the shots provided by these organizations are probably not counted.

Arnold Levy, M.D., Montgomery County, speaking on behalf of the physicians of Montgomery County, expressed

appreciation for the help extended to them for the Medicare problems many physicians in both Montgomery and Prince George's Counties had with Pennsylvania BlueCross Blue Shield. Other members participated in the questions and comments.

♦ *Certificates of appreciation*

Certificates of appreciation were presented by Allan D. Jensen, M.D., speaker of the house, to Dr. Godfrey, Mr. Carroll, Ms. Harvey, and Carol Messick, Medicare operations specialist, HCFA, for taking time to be at today's meeting.

♦ *Keynote speaker for the semiannual meeting*

Richard F. Corlin, M.D., vice speaker of the American Medical Association House of Delegates, who would give the keynote speech on the following day, was introduced. Dr. Corlin noted the importance of physicians' working out their agenda and being pragmatic, not ideological, when discussing the single payer system in their reference committees on the following day. He said there is no point of view that could be considered the best. The speaker of the house gave Dr. Corlin a certificate of appreciation.

♦ *Treasurer's report*

Carol W. Garvey, M.D., treasurer, said the budget being presented had been reviewed by both the Finance Committee and the Board of Trustees. Dr. Garvey said the budget presented was a bare-boned balanced budget. She also said that to continue to provide the services needed (e.g., government relations, additional FAX capabilities, and additional phone and support personnel), Med Chi would need to raise the dues to \$350. Dr. Garvey asked the House members to support the dues increase at the local component level. She also said small market reform is expected to decrease the amount of money realized by Med Chi from the Med Chi Agency. Dr. Garvey said the public relations campaign the House has requested would be borne this year by \$200,000 from the membership fund. This would be a one-time campaign and if the members wished to continue with future public relations campaigns, more money would be needed. It would be up to the House to decide how much money they wished to spend towards such a campaign in the future.

Albert Blumberg, M.D., Baltimore County, asked if the invoices to be sent to members would be simplified and it was noted that they would. Michael Dobridge, M.D., Montgomery County, former president, said he was a member of the Finance Committee and that he wanted to let the House know that Med Chi's finance department had worked very hard on the budget, and that the Finance

Committee had looked at the budget very carefully. He said he endorsed the dues increase.

Catherine N. Smoot-Hasselbus, M.D., Wicomico County, said there could be fallout (i.e., a decrease in membership) if the dues increase went through and cited a need to do some public relations to explain the need for a dues increase before the House voted for it.

David Nagel, M.D., Baltimore County, asked that the question be called.

Dr. Blumberg asked that the motion be clarified before the vote. It was agreed that the motion was the acceptance of the budget, the acceptance of a dues increase, and a change in the billing process.

The question was called and the House approved the budget, dues increase, and change in the billing form sent to members.

♦ *New business*

a. **HB 1359—\$5.00 laboratory fee**

Alex Azar, M.D., Wicomico County, said it had been suggested by the HCACC that laboratory fees be limited to \$5. He said if anyone had any input about this matter, they should contact either him or the lobbyist, Joseph Schwartz, III, Esq.

b. **CEO evaluation**

Marianne Benkert, M.D., Baltimore County, said the Retreat Committee had worked very hard, and she asked that the evaluation of the position of the CEO should be done as quickly as possible by the Board of Trustees Personnel Committee as set forth in the new bylaws. She moved to set a timeframe for the report.

Paul A. Stagg, M.D., Dorchester County, secretary, and chairperson of the Personnel Committee, noted that the Personnel Committee was recently appointed. He said that one meeting had been held and another one would be held the next day. He stressed that evaluation of the CEO needed to be done in a fair and equitable way and that it could not be hurried. He said he was unable to set a timeframe on when the evaluation should or would be completed and would appreciate the House's consideration.

There was further discussion of the need for the CEO evaluation process.

Dr. Azar amended the motion that the House receive a status report at its next meeting. The amended amendment was approved by the House.

c. **Needle exchange program**

Susan Guarnieri, M.D., Baltimore City, thanked the House for its support of the needle exchange program for

Baltimore City. She said the program has been considered successful.

♦ *Date of next meeting*

Sunday, September 11, 1994, at 10 a.m.

♦ *Adjournment*

There being no further business, the meeting was adjourned at 5 p.m.

Paul A. Stagg, M.D.

Secretary

Minutes of the Meeting of the House of Delegates *Sunday, September 11, 1994*

♦ *Members and guests present*

The list of members and guests present is available from the executive office of the Medical and Chirurgical Faculty of Maryland.

♦ *Call to order*

The meeting was called to order at 9:05 a.m. by the speaker of the house, Allan D. Jensen, M.D.

♦ *Report of Credentials Committee*

Melvin Rapelyea, M.D., co-chairperson of the Credentials Committee, reported that a quorum was present.

♦ *Reference Committee A*

Sheldon B. Bearman, M.D., chairperson of Reference Committee A, presented his committee's report. The committee included Drs. Beverly A. Collins, Alan T. Leffler, and Edward W. Lampton. The committee had reviewed suggested bylaws amendments, five-year resolutions, and a position paper on physician assistants. The House took the following actions:

- Amendment of Article V, Section 5.503 of the bylaws, as follows:

5.503 Speaker and Vice Speaker. There shall be a speaker and vice speaker of the House of Delegates who shall be nominated under the provisions of Article 8.00 of these bylaws and elected from the membership of the House at each annual general meeting. Any member may serve as speaker or vice speaker for a maximum of six consecutive terms in either position. The speaker, or in his or her absence the vice speaker, shall preside over all meetings of the House, *and as presiding officer, shall have the same right regarding voting, as every other delegate.*

- After much discussion, the House amended Reference Committee A's recommendation for amending Article

IX, Section 9.201, and it was approved with amendments from the floor as follows:

9.201 Council on Bylaws. The function of the Council on Bylaws shall be to draft amendments to the bylaws and rules of Med Chi as it deems they are needed or as directed by the House of Delegates or board of trustees. It shall review, approve, disapprove, or alter amendments submitted to it by component societies or councils. It shall report all amendments to the bylaws of Med Chi to the House of Delegates with the call to session. The council shall also serve as an advisory committee on all matters pertaining to the bylaws and the rules of Med Chi.

~~Information deleted.~~ [Line drawn through indicates approved deletion.]

Information approved. [Italicized information indicates approved new information.]

The Council shall be composed of a Bylaws Committee and a Rules and Regulations Committee and each committee shall consist of nine members, inclusive of the chair, including one representative from each of the following:

- a. Baltimore City;*
- b. Baltimore County;*
- c. Montgomery County;*
- d. Prince George's County*
- e. Western County Group (Allegany, Carroll, Frederick, Garrett and Washington Counties);*
- f. Eastern County Group (Caroline, Cecil, Dorchester, Harford, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester Counties);*
- g. Southern County Group (Anne Arundel, Calvert, Howard and St. Mary's Counties);*
- h. Two-at-large members, only one of whom shall be from the small component societies. The Chair of each*

committee shall not serve as the chair of the other committee. This change will go into effect in May 1995 (after the annual meeting).

- The House of Delegates approved Reference Committee A's recommendation that the suggested amendment to Article V, Section 5.50 c, d, and e not be approved. Therefore, the members of the board of trustees (except for the speaker and vice speaker) will *not* have a vote in the House of Delegates.

- **Resolution 1A/89—Student and Resident Participation.**

The resolution was reaffirmed as recommended by Reference Committee A as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland continue to involve its student and resident members in appropriate levels of Faculty activities.

- **Resolution 2A/89—Natural Sciences Ambassador Project.**

The Reference Committee recommended that this resolution not be reaffirmed since this project had never been established and currently there was not a need for this project. This recommendation was approved by the House of Delegates.

- **Resolution 3A/89—Ophthalmic Surgical Care.**

The House approved the Reference Committee's recommendation that Resolution 3A/89 be reaffirmed by deletion to read as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland asserts that, in keeping with the sound professional practice of medicine, the provision of postoperative medical eye care is the responsibility of the ophthalmologist ~~and can be neither legally nor ethically delegated to a non-physician.~~

- **Resolution 4A/89—Women Physicians in Organized Medicine.**

The House approved the Reference Committee's recommendation that the resolution be reaffirmed as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland in cooperation with its component societies, actively recruit women physicians to actively participate in organized medicine through increased committee and other leadership involvement.

RESOLVED, That the Medical and Chirurgical Faculty of Maryland encourage women physicians to

actively participate in organized medicine through increased committee and other leadership involvement.

- **Resolution 5A/89—Establishment of a Maryland Healthcare Delivery Alliance.**

Reference Committee A recommended that the House not reaffirm this resolution because this alliance no longer exists and communication with MHA and MNA is available through the Maryland Health Care Alliance and the Health Care Provider Coalition. The recommendation was carried by the House of Delegates. Therefore, the resolution was not reaffirmed.

- **Resolution 1S/89—Condemnation of Use of Anabolic Steroids in Enhancement of Athletic Performance.**

The Reference Committee suggested that this resolution be reaffirmed by the House and it was as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland hereby universally and unequivocally condemns the use of anabolic steroids to enhance athletic performance;

RESOLVED, That anabolic steroids be used only under the prescription of a licensed physician for medically indicated purposes; and be it further

RESOLVED, That the Medical and Chirurgical Faculty work with the Office of the Governor, as well as with the state legislature in all efforts to endorse educational activities aimed at appropriate interested individuals such as sports group administrators, coaches, trainers, parents and athletes to curb the non-medical use of anabolic steroids.

- **Resolution 2S/89—Medical Care Review.**

The Reference Committee recommended that the resolution be reaffirmed by deleting and inserting wording and the House approved the recommendation as follows:

~~RESOLVED, That the Medical and Chirurgical Faculty of Maryland strongly condemns HCFA's system of nomenclature because it would encourage an increase in law suits by de facto underwriting of legal decisions without due process of law; and~~

RESOLVED, That the Medical and Chirurgical Faculty of Maryland, *which represents all physicians in Maryland and the state-of-the-art of medicine in Maryland*, encourages "medical care review" for the purpose of improving the medical care of our state

residents-, but that This review process *should* be one of education and rehabilitation, rather than the destructive process of encouraging litigation, which it condemns; and be it further

RESOLVED, That the Medical and Chirurgical Faculty of Maryland which represents all physicians in Maryland and the state of the art of medicine in Maryland, consult with the PRO (Delmarva Foundation of Medical Care) in order to clarify these issues so that the end result would not be to compound the malpractice crisis.

• **CSA Report 1-94—Physicians Assistants-Prescribing and Dispensing.**

The Council on Scientific Affairs, in order to develop recommendations to the House of Delegates, carefully considered information on the subject and found several basic issues which it felt should be addressed before supporting final regulations regarding PA prescribing. After referencing the subject, Reference Committee A recommended changes to the Council on Scientific Affairs' recommendation. Additionally, the House made recommendations that were approved. The report as approved in final form with all additions was adopted by the House as follows:

The Council on Scientific Affairs, in order to develop recommendations to the House of Delegates, has carefully considered all of the information contained above. We find several basic issues which should be addressed before supporting final regulations regarding PAs writing medication orders:

1. Education and Training

The BPQA should support the requirement for a bachelor's degree and at least 10 hours of continuing education annually in the specific field of pharmacology for which the prescriptions are being written.

2. Physician Relations

All PAs must be under the supervision and direction of a licensed physician who may not be responsible for more than three such persons.

3. Formulary

The PA may employ only those medications listed in a state formulary to be developed through a committee, including, but not limited to, BPQA, Board of Pharmacy, and Medical and Chirurgical Faculty of Maryland.

4. Protocols

The PA may only transcribe from specific written protocols prepared by the supervising physician, or

when practicing in an institution, by that institution's medical review committee. The protocol must be maintained along with other policies and procedures by the supervising physician and/or the institution. Protocols and revised protocols must be submitted to the committee noted in number three (3) and may be modified by that committee.

5. Site of Practice

PA writing of medication orders should be limited to those institutional areas where medical hardship and lack of alternative physician resources exists. These areas would include:

- a. Health Professional Shortage Areas (HPSAs) (These areas include shortages in particular medical disciplines);
- b. MQHC or FQHC (Maryland/Federal Qualified Health Centers); and
- c. State-related institutions.

The Council on Scientific Affairs recommends that the House of Delegates request BPQA to respond to the five issues raised above, and, if favorable response is received, then would recommend that the current Maryland proposed "Draft" regulations be supported with the exception that hospital transcribing only be permitted within a facility meeting criteria stated in Site of Practice above.

♦ **Reference Committee B**

Howard Silby, M.D., chairperson of Reference Committee B, presented the committee's report. Other members included Drs. Willarda Edwards, David O'Brien, and Roland Smoot.

Reference Committee B gave careful consideration to the resolutions referred to it. The following resolutions were discussed and the final conclusion is noted:

• **Resolution 15-94—Conduct of a Peer Review Prior to Litigation**

Reference Committee B had recommended that this resolution be adopted with additions and deletions. However, the House asked that the resolution be referred to the board of trustees for decision as amended by the House as follows:

RESOLVED, That the Board of Trustees of the Medical and Chirurgical Faculty work with the Board of Physician Quality Assurance to find a mechanism which would disallow the discoverability of peer review prior to the institution of litigation; and be it further

RESOLVED, That the Board of Trustees be asked to report back to the House of Delegates at its next scheduled meeting.

• **Resolution 16-94—Inappropriate Questions on Applications**

Reference Committee B had recommended that this resolution be adopted with deletions and additions. The House referred the resolution for decision to the board of trustees as it was amended by the Reference Committee as follows:

RESOLVED, That the Board of Trustees of the Medical and Chirurgical Faculty work with the Board of Physician Quality Assurance and the Maryland Hospital Association to remove the question about whether a physician is currently or has ever been the subject of a peer review from applications and other official forms, and to substitute a question on applications and official forms regarding whether any disciplinary peer review action has been taken; and be it further

RESOLVED, That the Board of Trustees be asked to report back to the House of Delegates at its next scheduled meeting.

• **Resolution 17-94—Single Payer System**

Reference Committee B had recommended that this resolution be adopted with additions and deletions. The House passed additional amendments to the resolution. The resolution as approved by the House is as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland continue to explore all health systems options for

- creating a universal comprehensive and equitable health care system whose structure and function addresses the concerns of the American Medical Association regarding guaranteeing an active role of organized medicine nationally and locally in setting proper fees and policies;
- creating a budget that is flexible to demand;
- maintaining physician autonomy;
- maintaining fee for service;
- maintaining freedom of choice of physicians;
- protecting physician-patient relationship;
- maintaining openness to new technology and treatments;
- maintaining a parity of coverage and reimbursement;
- promoting high quality care;

- simplifying billing, reimbursement and administration to keep those costs to a minimum;
- developing an equitable and adequate funding system; and
- maintaining flexibility and responsiveness to the public needs.

Additionally, during the discussion of this resolution, it was noted that Med Chi drew up a survey regarding this issue some time ago and that it should be utilized to survey the membership. Staff was instructed to locate the information and to survey the membership.

• **Resolution 18-94—Single Unified Explanation of Benefit**

Reference Committee B recommended that this resolution be adopted as amended by the committee. The House adopted the committee's recommendation and the resolution as approved is as follows:

Be it therefore resolved, that there should be formulated a single unified explanation of benefit form (EOB) which all insurance companies and HMOs would have to use as their notification of explanation of benefits to the providers of care and to the patient, as well as a uniform consultation referral form and uniform laboratory referral form, and be it further

RESOLVED, That this policy be referred to the Council on Legislation and Council on Medical Services for implementation.

• **Resolution 19-94—Physician's Right to Safety While Practicing Medicine.**

Reference Committee B recommended that the House adopt the resolution as presented. The House adopted the resolution without any amendments as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland condemn the abortion clinic related killings which occurred in Florida, and be it further

RESOLVED, That Med Chi reaffirm AMA policy opposing violence against any facility, including abortion clinics and family planning clinics.

• **Resolution 20-94—Anencephalic Infants as Organ Donors.**

Reference Committee B recommended that this resolution not be adopted and the House approved Reference Committee B's recommendation. Therefore, Med Chi continues to support the AMA's position, which allows anencephalic infants to be donors.

Alex Azar, M.D., an AMA delegate, noted that this matter came up at the AMA meeting and that only two Maryland physicians, out of numerous experts from around the country, took the stand Med Chi had been asked to take through this resolution.

• **Resolution 21-94—AZT Treatment for HIV+ Gravidas.**

Reference Committee B recommended that this resolution be adopted as amended by the Reference Committee. The House approved the committee's recommendation of the resolution as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland recommends that all gravidas be offered and encouraged to utilize HIV antibody testing; and be it further

RESOLVED, That the Medical and Chirurgical Faculty of Maryland recommends offering AZT to HIV+ gravidas with the aim of reducing HIV transmission to the fetus. This should include informed consent that the long-term effects of AZT are as yet unknown.

• **Resolution 22-94—Twenty-Four Hour Discharge for Uncomplicated Pregnancies.**

Reference Committee B recommended that this resolution be adopted as it was presented and the House approved the resolutions as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland support the following recommendations approved by the consensus group:

1. The earliest time of discharge for mother and baby should be at least 48 hours following delivery.
2. If discharge is to occur sooner than 48 hours from delivery, the following should be maintained:
 - a. Discharge should not occur before 24 hours of milk feeding. Since most babies are not fed milk until three to four hours after birth, that means 27-28 hours after birth should be the earliest possible discharge.
 - b. No baby should leave the hospital without informed consent for metabolic screening having been discussed with the mother and the initial specimen obtained.
 - c. The mother and baby must have one overnight in the hospital after delivery prior to discharge.
 - d. The mother and baby must satisfy the criteria for discharge in the *Guidelines for Perinatal Care*.
 - e. Appropriate surveillance of mother and baby must be established either with home visits, office

visits or hospital stay.

- f. No mother or baby should be discharged without being linked to a continuing care provider.

♦ **New business**

Baltimore City presented a late resolution asking that only one meeting of the House be held during the semianual meeting and that that meeting be held on Saturday. The speaker said this resolution had not been received before the deadline for resolutions to be heard at this meeting and it was suggested that the resolution be submitted for the next House of Delegates meeting.

Harvey Fernbach, M.D., Montgomery County, said he would appreciate having adequate time to debate resolutions during both the reference committee hearings and the House meetings. He said in both the reference committee meeting and the House meeting today, he was limited in the time for debate. The speaker said the good of the House is to allow sufficient debate on both sides of the issue.

Mayer C. Liebman, M.D., Baltimore County, said the reference committees were very informative and he enjoyed those meetings; he also said they were an improvement.

John Newby, M.D., Washington County, said members needed to look at the reference committee process and establish rules as to how to limit debate and define a time limit for debate.

♦ **Next meeting**

The chairperson said the next House of Delegates meeting will be held either January 21 or 28, 1995, and that staff would let members know the date when they send out the minutes. Albert Blumberg, M.D., Baltimore County, said Baltimore County's next annual meeting will be January 21 and asked that the House of Delegates meeting be held January 28. The speaker said the next meeting would be held January 28, 1995.

The speaker announced that the annual meeting will be May 4-6, 1995, in College Park, Maryland.

♦ **Adjournment**

There being no further business, the meeting was adjourned at 12:40 p.m.

Paul A. Stagg, M.D.
Secretary

HEPATITIS B FACT SHEET

Hepatitis B is an infection of the liver caused by the hepatitis B virus (HBV)

The virus is in blood and other body fluids

The virus is in blood, semen, menstrual blood, and other body fluids of a person with hepatitis B. 5-10% of adults and about 90% of babies who catch hepatitis B will go on to "carry" or keep the virus for the rest of their lives. "Hepatitis B carriers" can pass the virus on to others.

Hepatitis B virus is spread by exposure to blood and body fluids

The virus can be spread during sex, by sharing needles, by getting stuck with a dirty needle, or by getting blood or other infected body fluids in the mouth, eyes, or onto broken skin. The virus also can be passed from mother to baby, usually at the time of birth. The virus is not spread by shaking hands, hugging, sharing food or drink.

Some people are a higher risk of hepatitis B:

- Drug users who share needles
- Men who have sex with other men
- Anyone who has unprotected sex with a man or woman who has the hepatitis B virus
- Anyone who has many sex partners
- Babies born to mothers who have the virus
- People born in Asia, the Caribbean, South America, Africa, the Pacific Islands and their children, as well as native Americans and native Alaskans
- People who have hemophilia or who are on kidney dialysis
- Health care workers, emergency workers, laboratory workers, and others who have contact with blood and body fluids
- People who live with a person who is a hepatitis B carrier
- People who live or work in institutions for the mentally retarded

Symptoms to look for:

- Tiredness
- Loss of appetite
- Fever
- Vomiting
- Yellow skin and eyes (jaundice)
- Dark-colored urine, light stool

Most children and about half of all adults who get hepatitis B never feel sick at all. For these people, it takes a blood test to tell if they have the virus. The blood test may not show the infection until 2-6 months after contact with the virus. Carriers are at risk of liver problems later in life, like liver cancer or cirrhosis.

Treatment for hepatitis B:

People who are sick with hepatitis B need rest, fluids, and the right diet. This means avoiding alcohol and some medicines. Certain carriers may need medications such as interferon. Ask your doctor for further information.

Prevent hepatitis B

Avoid exposure: Use latex condoms (rubbers) when you have sex; don't share needles; don't share personal care items like toothbrushes, razor blades, or nail clippers; avoid exposure to blood and body fluids at work.

Get vaccinated: If you are in "close" contact with someone with the virus (sex partner, mother-baby contact, sharing needles, living in the same house with a carrier), or if you work in contact with blood, ask about getting three shots of hepatitis B vaccine to protect yourself. Babies born to mothers with the virus should get the vaccine and a shot called HBIG (hepatitis B immune globulin). Routine hepatitis B vaccination of all newborn babies is now recommended.

Tell certain people—and don't donate blood: People who are sick with hepatitis B or who are carriers should tell their doctors, dentists, and people they have sex with or share needles with. And remember, don't donate blood if you have, or ever had hepatitis B, even if you never felt sick.

HEPATITIS C FACT SHEET

Hepatitis C is an infection of the liver caused by the hepatitis C virus

The virus is in blood and other body fluids

The virus can be found in the blood, semen, menstrual blood, and other body fluids of a person with hepatitis C. It is believed that most people who catch hepatitis C will go on to carry the virus in their blood and other body fluids for the rest of their lives, and could pass the virus on to others.

Hepatitis C virus is spread by exposure to blood and body fluids

The virus can be spread by transfusion of blood containing hepatitis C virus and by sharing dirty needles used to shoot drugs. Since 1992, all donated blood in the U.S. has been tested to detect blood infected with hepatitis C virus. The virus is not spread by causal contact such as shaking hands, hugging, sharing food or drink.

Certain people are at higher risk of having hepatitis C

Anyone can catch hepatitis C, but some people are more likely to catch it. People at higher risk are:

- People who received blood transfusions before 1992
- Drug users who share needles

Other people who may be at increased risk are:

- Anyone who has unprotected sex with a man or woman who has acute hepatitis C or who is a hepatitis C carrier
- Babies born to mothers who have hepatitis C
- Health care workers, dental care workers, emergency workers, laboratory workers, and others who have contact with blood and body fluids

Symptoms to look for:

- Tiredness
- Loss of appetite
- Abdominal pain
- Nausea
- Vomiting
- Yellow skin and eyes (jaundice)
- Urine that is dark in color

It takes 2 weeks to 6 months from the time of exposure until a person gets sick, but most commonly 6 to 9 weeks. Many people infected with hepatitis C have no symptoms at all and only find out they are infected when they have blood tests for liver function or hepatitis C.

There is limited treatment for hepatitis C

People who are sick with hepatitis C need rest and fluids. Some people need to be hospitalized or may need other medications. Ask your doctor to explain how alcohol and some medicines may hurt your liver.

Prevent hepatitis C: avoid exposure, and practice good hygiene

Those at risk should be careful to avoid getting exposed: injectable drugs users should not share needles or works with others; use of latex condoms may decrease the risk of catching or passing hepatitis C virus through sex.

HERPES FACT SHEET

Herpes is an infection caused by herpes simplex virus (HSV)

This virus has two types, HSV type 1 and HSV type 2. HSV type 2 is more often associated with sexual activity and causes more genital infections, but either virus can infect any site. Both viruses can become "latent" in nerve cells and can cause recurrent symptoms.

Almost everyone has had HSV type 1

50% to 90% of adults have had HSV1 infection. Infections in children are often mild or cause no symptoms at all. Even if you have had HSV type 1, you can still catch HSV type 2.

Oral Herpes (mouth, lips)

The virus is passed from person to person by contact with the blisters or sores. This occurs with:

- Kissing or other direct contact with "cold sores"
- Touching the blisters or sores

Symptoms to look for:

- Painful small bumps on the lips or mouth that turn into blisters and then into open sores (also known as "fever blisters" or "cold sores.")

Genital Herpes

The virus is passed from person to person by contact with the blisters or sores. This occurs with:

- Having sex (especially if not using a condom)
- Touching the blisters or sores
- From a mother to baby at the time of birth if the mother has genital herpes

Symptoms to look for:

- Painful blisters that become sores on the penis in men, or on the external or internal genitals of women.

Symptoms may start about 2 to 12 days after infection. The first time a person has these symptoms is usually the worst. The virus stays in a person's nerve cells and then can cause similar symptoms again later. The herpes skin lesions usually come back again at the same place they first appeared. This can happen when a person is under stress, has a fever, is exposed to the sun, etc. Herpes is more common near the time when a woman has her period. The symptoms of HSV last for about a week or two.

Herpes can cause severe infections in babies and in people at high risk

Newborn babies and young infants are at highest risk of herpes infections. They can get severe skin infections and brain infections that can lead to mental retardation or death. Adults also rarely get brain infections (encephalitis) as a complication of herpes. Infections can be more severe in people who have problems with their immune system.

Prevent herpes infections by avoiding contact with sores and by good hygiene

People with herpes infections of the lips should not kiss babies or get their mouth close to a baby. They should also wash their hands very well before touching a baby. People with herpes infections of the lips should not kiss anyone on the mouth or genitals until the sores are healed. Keeping toys clean and limiting saliva contact will help prevent infections among children. Students and employees known to have herpes are not routinely excluded from schools or child care centers. Gloves should be worn if touching open lesions. Covering lesions and handwashing will limit spread.

Persons with genital herpes can prevent infections by not having sex until the lesions have healed and by using a condom.

Treatment with acyclovir may help

A drug called acyclovir (Zovirax) is often prescribed for genital herpes. It can lessen the symptoms of herpes and decrease the amount of virus shed.

Pregnant women who have had herpes should tell their doctor

If a woman has ever had genital herpes, she should tell her doctor. She will need to be watched closely during her pregnancy and her doctor may even recommend a cesarean section to avoid exposing her newborn during birth.

IMPETIGO FACT SHEET

Impetigo is a common skin infection in young children

It is caused by streptococcal or staphylococcal bacteria.

A rash appears 4 to 10 days after exposure

The rash looks red and round, and may be oozing. It can occur as small blisters containing pus-like material that may break and form a flat, honey-colored crust. The rash is most commonly seen on the face and around the mouth, but can occur any place on the skin. It is often itchy.

Impetigo is spread through direct contact with infected skin

Less commonly it can be spread through touching articles (such as clothing, bedding, towels, etc.) contaminated with the blisters.

A person with impetigo should:

- Wash the rash with soap and water and cover it loosely with gauze, a bandage, or clothing
- Wash hands thoroughly, especially after touching an infected area of the body
- Use separate towels and washcloths
- Avoid contact with newborn babies
- Be excluded from school or day care until 24 hours after the start of treatment
- Be excluded from foodhandling until 24 hours after the start of treatment

Treatment is available

Topical treatments and/or antibiotics are available. See your doctor.

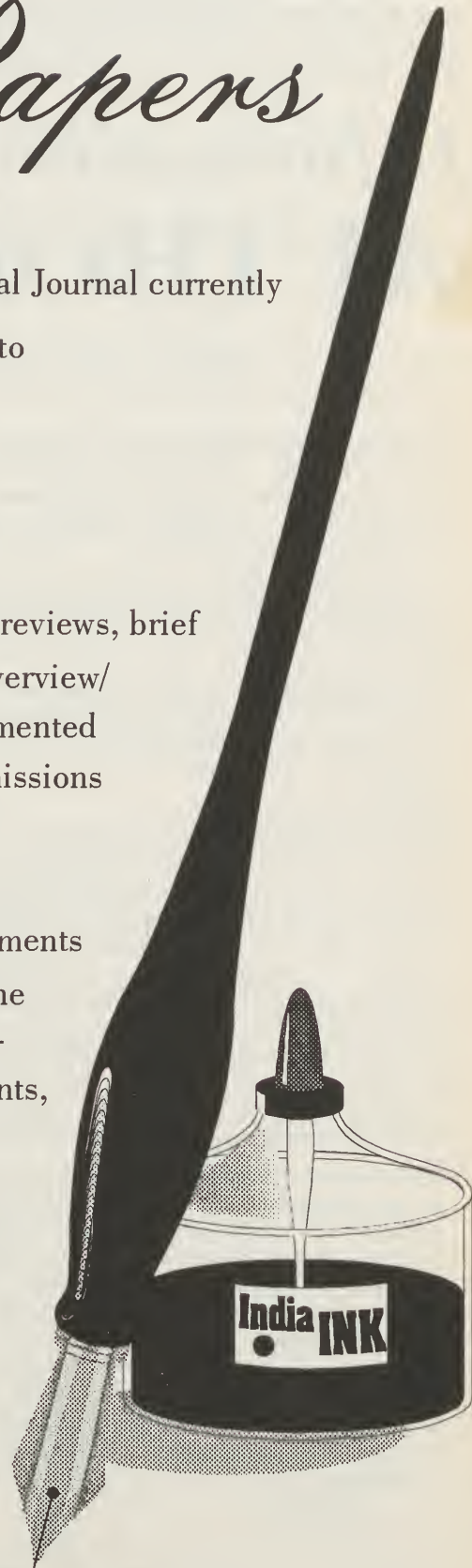
Call for Papers

The Editorial Board of the Maryland Medical Journal currently seeks original articles addressing topics related to

- Pain Management
- Patient Education
- Patients with Handicapping Conditions

Papers may be original research, literature reviews, brief reports, case histories accompanied by a brief overview/summary of the relevant literature, or well-documented opinions about future trends. Deadline for submissions is February 15, 1995.

All submissions should conform to requirements listed on the "Information for Authors" page of the *Maryland Medical Journal*. For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor, 1211 Cathedral Street, Baltimore, MD 21201; 410-539-0872 or 1-800-492-1056; FAX 410-547-0915.



The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the MMJ in the event that the work is published.

- **Manuscript preparation**—Manuscripts should be submitted to Editor, MMJ, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- **Permissions**—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the MMJ to reproduce the information/figure.

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Accepted manuscripts become the permanent property of the MMJ and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset.

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, Maryland 21205 (410-955-2959).

| | |
|--|-------------|
| Ophthalmic update for the medical practitioner | Nov. 18 |
| Fifth annual neurology for the primary practitioner at the Harbor Court Hotel, Baltimore, MD. 6 Cat 1 AMA credits. | Dec. 3 |
| Seventh annual Wilmer Institute current concepts in ophthalmology, 20 Cat 1 AMA credits. | Dec. 8-10 |
| Memory and reality: Reconciliation. Scientific, clinical and legal issues of false memory syndrome, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: Postmarked before Oct. 1: \$300/professionals; \$125 families (includes 2 family members); postmarked after Oct. 1: \$400/professionals; \$275 families (includes 2 family members). | Dec. 9-11 |
| Basic comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. \$850/labs and lectures; \$325/lectures only. | Jan. 12 |
| Advanced comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. \$1400/labs and lectures; \$495/lectures only. | Jan. 13-14 |
| Advances in cardiac diagnosis and treatment 1995, at the Sheraton Baltimore North, Towson, MD. Cat 1 AMA credits available. Fee: TBA. | Jan. 19-20 |
| Frontiers in research and clinical management of age-related macular degeneration, 8 Cat 1 AMA credits. Fee: \$225/physicians; \$125/residents, fellows, allied health professionals. | Jan. 20-22 |
| Advances in cardiac diagnosis and treatment, 18 Cat 1 AMA credits. | Jan. 20-22 |
| 1995 Update in the management of age-related macular degeneration, 8 Cat 1 AMA credits. Fee: \$225/physicians; \$125/residents, fellows and allied health professionals. | Jan. 21 |
| 22nd Annual geriatrics symposium: Primary care for the practitioner, at the Stouffer Harborplace Hotel, Baltimore, MD. 20 Cat 1 AMA credits available. | Feb. 2-4 |
| 12th Annual Houston Everitt Memorial Course in urogynecology, 17 Cat 1 AMA credits. | Feb. 24-25 |
| Pain treatment centers at a crossroads: a practical and conceptual reappraisal, Cat 1 AMA credits TBA. | March 3-5 |
| Nuclear oncology, 16 Cat 1 AMA credits. Fee: \$495/physicians; \$395/residents, fellows, allied health professionals. | March 8-10 |
| Principles and practice of clinical MRI, at the Renaissance Hotel, Washington, DC. 21.5 Cat 1 AMA credits. | March 23-26 |
| Fifth annual perspectives on clinical nutrition, 11 Cat 1 AMA credits. | March 24-25 |
| Spectrum of developmental disabilities XVII, 20 Cat 1 AMA credits. | March 27-29 |
| Diagnosis and treatment of neoplastic disorders, 13.5 Cat 1 AMA credits. | March 30-31 |
| 36th Annual postgraduate institute for pathologists in clinical cytopathology, 136 Cat 1 AMA credits. | |
| Course A (Home Study) | Feb-March |
| Course B (Johns Hopkins Medical Institutions) | April 3-14 |

The Johns Hopkins Medical Institutions (continued)

The care of patients with Alzheimer's and other dementias, at the Stouffer Harborplace Hotel, Baltimore, MD. 5.5 Cat 1 AMA credits available. Fee: \$120/physicians; \$75/residents, fellows, allied health professionals. **April 1**

Advanced pediatric life support courses, 20 Cat 1 AMA credits. Fee: \$525. **June 12-14**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Advances in epilepsy, at the Harbor Court Hotel in Baltimore, MD. 5.5 Cat 1 AMA credits. Fee: \$35. Info: Catherine Bowers 410-828-7700. **Nov. 14**

R. Adams Cowley 16th annual national trauma symposium, at the Hyatt Regency, in Baltimore, MD. Info: 410-328-2399. **Nov. 16-20**

AIDS: A challenge to primary care, at the Convention Center in Baltimore, MD. 11 Cat 1 AMA credits. Fee: \$225. Info: Carol Kowarski, 410-706-8562. **Dec. 2-3**

Miscellaneous meetings

Hemodialyzer reuse in the 1990s, sponsored by the Association for the Advancement of Medical Instrumentation, at the Crystal City Marriott, Washington, DC. Cat 1 AMA credits available. Fee: \$225/members; \$275/nonmembers. **Nov. 15**

The second annual Maryland schizophrenia conference, at the Pikesville Hilton Inn, Baltimore, MD. 3 Cat 1 AMA credits. Fee: \$35. Info: Joan Bush, M.D. 410-455-7666. **Dec. 1**

Recent advances in male infertility, sponsored by the Greater Baltimore Medical Center at GBMC in Baltimore, MD. 5.5 Cat 1 CME credits. Fee: \$40. Info: 410-828-3670. **Dec. 5**

Miscellaneous meetings (continued)

- Cardiovascular conference at Snowshoe**, sponsored by the American College of Cardiology at the Mountain Lodge Conference Center, Snowshoe, WVA. 14.5 Cat 1 AMA credits. Info: 1-800-257-4739. **Feb. 6-8**
- Fourth annual spring clinical nephrology meetings primary care nephrology program**, sponsored by the National Kidney Foundation at the Sheraton Washington Hotel, Washington, DC. Info: 1-800-622-9010. **March 24-25**
- Clinical perspectives on violence conference**, at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: Professional Education Programs, 410-938-4598. **March 25**
- Third world congress on stress, trauma and coping in the emergency services professions**, at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311. **April 19-23**
- Clinical innovations in OB/GYN ultrasound**, sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine, at the Lowes L'Enfant Plaza in Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by ACOB/GYN. Info: Ann Boehme 516-561-4223. **April 22-23**
- Caring for the diabetic lower extremity: a practical approach for primary health care providers**, sponsored by the American Diabetes Association at the Sheraton International Hotel, BWI Airport. 7 Cat 1 AMA credits. Fee: \$125/physicians; \$100/ACP members; \$75/other health professionals. Info: 410-526-2900. **April 28**



PHYSICIAN'S RECOGNITION AWARD

During September 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Jess V. Barbers, M.D.
Charles H. Evans, M.D.
James L. Hall, M.D.
Abolghassem Hatef, M.D.
Howard C. Hines, M.D.
A. Clark Holmes, M.D.

Leela Krishnamurthy, M.D.
Arinola Lawson, M.D.
Scott Duk Mann Moon, M.D.
Carolyn B. O'Connor, M.D.
John F. O'Neill, M.D.
George M. Pellegrino, M.D.

Stephen D. Rosenbaum, M.D.
James A. Rossi, M.D.
Frederick G. Weinstein, M.D.
Frederick H. Wilhelm, M.D.

Miscellaneous meetings (continued)

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month, 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

“OB/GYN topic”

Dec. 1

“Tumor conference”

Dec. 8

“Infectious disease topic”

Dec. 15



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November, 1994

Recommendations for Screening Pregnant Women for Hepatitis B Virus and for Managing Their Infants and Contacts

The following are the Maryland Department of Health and Mental Hygiene (DHMH) recommendations for screening pregnant women for hepatitis B virus (HBV). Aimed at identifying hepatitis B surface antigen (HBsAg)-positive pregnant women and preventing HBV infection in newborns, these recommendations expand upon general Centers for Disease Control and Prevention (CDC) recommendations to perform HBV screening at an early prenatal visit.

Perinatal transmission is one of the primary modes of HBV infection in children. Infants born to HBV-infected women have between a 10% and 85% chance of acquiring HBV infection perinatally. Of infants infected during the perinatal period, 85%-90% will become chronic carriers of the virus and up to 25% of these carriers will die of chronic liver disease in adulthood. The risk of vertical or perinatal transmission depends upon the mother's hepatitis B "e" antigen (HBeAg) status. Since the presence of HBeAg correlates with high levels of viral replication and therefore high infectivity, infants born to women who are "e" antigen positive have a much higher risk of acquiring infection at birth. Despite the mother's HBeAg status, however, her management and that of her newborn remain the same.

There are six recommendations:

- Screen all pregnant women;
- Rescreen late in pregnancy all women who were HBsAg-negative but who were at risk of having acquired HBV during pregnancy;
- Assure proper management of infants born to women with HBV;
- Report pregnant women with HBsAg to the local health department;
- Manage (or refer) the woman with HBV; and,
- Manage (or refer) the woman's contacts (household and sexual).

Prenatal screening will allow the health care provider to identify women with HBV and to assure appropriate prophylaxis of their infants. Additional screening will enable the obstetrician caring for HBsAg-positive women to provide these women with useful information concerning their HBV status and will enable identification of uncommon false positive HBsAg results which appear to be increased during pregnancy.¹

The rationale for prenatal screening is to eliminate morbidity and mortality associated with perinatal hepatitis B transmission. Other

¹ Verbal communication, Stephen Lambert, M.S., Chief, Hepatitis Reference Diagnostic Unit, Hepatitis Branch, Centers for Disease Control and Prevention.

advantages of HBV screening in pregnancy include:

- Identification of hepatitis B surface antigen (HBsAg) carriage in pregnancy to ensure appropriate management of neonate;
- Health education and referral for long-term medical management for the HBV infected woman; and,
- Testing and vaccination of sexual and household contacts at risk for HBV infection.

RECOMMENDATIONS

1. Screen all pregnant women.

All pregnant women should be routinely tested for hepatitis B surface antigen during an early prenatal visit in each pregnancy. Women who have not had prenatal HBsAg testing should have blood drawn immediately for such testing as soon as they are admitted for delivery. **Tests for other markers are not necessary on a routine basis for the purpose of maternal screening.** Table 1 gives test interpretations.

2. Rescreen late in pregnancy, women who were initially HBsAg negative but who are at risk of infection during pregnancy.

HBsAg testing should be repeated late in pregnancy for women who are HBsAg negative, but who are at high risk of infection (e.g. injecting drug users [IDUs], those with a documented exposure to HBV, those with multiple sex partners, and those with intercurrent sexually transmitted diseases) or who have had clinically apparent hepatitis.

Offering HBV vaccine to susceptible high risk women or offering hepatitis B immune globulin (HBIG) to pregnant women who

recently had parenteral or sexual exposure to an infected person is appropriate (Table 3). There is no known contraindication for administration of hepatitis B vaccine or HBIG during pregnancy. Public funding for vaccination of pregnant women at risk is not available at this time, but will soon be available for those 18 years old and younger who qualify for the Vaccines for Children Program (VFC).

3. Assure proper management of infants born to HBsAg-positive mothers.

All HBV test results, positive or negative, should be included in the woman's medical record and sent to the intended delivery site prior to delivery. HBsAg-positive results and test date should be prominently noted at the front of the patient's chart.

A system should be in place to ensure that the mother's positive HBsAg status is shared with the pediatrician. Infants born to mothers with HBV should receive 0.5 ml of hepatitis B immune globulin and the first dose of hepatitis B vaccine by intramuscular injection at separate sites, preferably within 12 hours of birth. The dose of hepatitis B vaccine for these infants is 5 μ g (0.5 ml) Recombivax HB (Merck Sharp & Dohme, High-risk infant/adolescent formulation) or 10 μ g (0.5 ml) Engerix-B (SmithKline Beecham) (Tables 2 and 3).

NOTE: If Recombivax HB is used for subsequent doses at 1 month and 6 months of age, it is important that the physician use the High-risk infant formulation.

Although HBV has been isolated from the breast milk of carriers, there is no evidence that breastfeeding increases the risk of HBV infection even in unimmunized infants. Theoretically, the virus may be ingested through blood or serum in the presence of cracked nipples, but it appears

that most infants who become infected acquire HBV around the time of labor and delivery. Therefore, breastfeeding is *not* contraindicated in infants born to HBsAg-positive mothers, especially if immunoprophylaxis is begun at birth. HBsAg-positive mothers should be encouraged to breastfeed if they wish.

Follow-up testing of the infant for HBsAg and anti-HBs is recommended at 9 to 15 months of age, at least one month after the third dose is given.

4. Report pregnant HBsAg-positive mothers to your local health department.

All acute hepatitis B cases must be reported to local health departments in jurisdictions outside Baltimore City. Health care providers in Baltimore City are required to report any case of acute or chronic HBV infection to the Baltimore City Health Department. Although not required by regulation outside of Baltimore City, it is recommended that physicians report HBsAg-positive pregnant women to their local health department to allow appropriate follow-up.

All laboratories in Maryland are required to report HBsAg-positive results to the local health department.

5. Refer or manage the woman who is HBsAg-positive.

- a. For women with a first time confirmed² positive HBsAg result: Further evaluate the woman in order to corroborate the HBsAg result, to identify the stage of HBV illness (acute vs. chronic), and to determine

the degree of HBV-related liver disease. The obstetrician may either manage the case or refer the woman to an appropriate specialist (internist, family physician, gastroenterologist) for management.

Assess for signs and symptoms of liver disease and obtain the following additional serologies (See interpretation of HBV serology-Table 1):

- (1) IgM class antibody to hepatitis B core antigen (HBcoreIgM) or Total hepatitis B core antibody (anti-HBc) followed by HBcoreIgM if anti-HBc is positive.
- (2) Hepatitis B "e" antigen (HBeAg) and antibody to HBeAg (anti-HBe).
- (3) Liver function tests.
- (4) Antibody to hepatitis C and hepatitis D if woman is an injecting drug user (IDU).

b. For women with acute hepatitis B:

If the HBcoreIgM is positive, the patient is likely to have recent acute hepatitis B and, when the acute infection resolves, may clear the HBsAg in a few months. Women with acute hepatitis B should be retested for HBsAg and antibody to HBsAg (anti-HBs) in 3-6 months to check for resolution of the HBV infection. Repeating HBsAg testing sooner than 3 months is not recommended because it will not provide any additional information, is costly without benefit, and subjects the patients to unnecessary bloodwork.

c. For women with chronic HBV infection (i.e., chronic carrier, defined as HBsAg-positive on 2 separate specimens at least 6 months

² HBsAg-positive results are "confirmed" by obtaining positive results when the specimen is retested in duplicate and/or with a neutralization test.

apart, or HBsAg-positive and HBcoreIgM-negative on the same specimen):

If HBcoreIgM is negative, or if the HBsAg is still positive six months after the initial test, the patient is likely to have chronic HBV infection (i.e., be a hepatitis B carrier) and should be referred for long term medical management. If the woman has elevated liver function tests, chronic hepatitis should be ruled out. If chronic hepatitis persists or worsens, interferon treatment should be considered and referral to a gastroenterologist is appropriate.

- d. For women who are injecting drug users with chronic HBV infection:

If the woman is hepatitis D virus (HDV) and/or hepatitis C virus (HCV) antibody negative, counsel on the risks of acquiring additional hepatitis viruses through injecting drug use. Refer to drug treatment.

- e. For women with HBsAg positivity as the **only** marker of HBV infection:

Rarely, a reactive HBsAg result occurs in the absence of any other reactive HBV serologic marker. This finding is most likely indicative of a false positive HBsAg result. The woman should be counseled about the indeterminate results and she should be retested for HBsAg, preferably after delivery. Conservatively, the infant should be managed as if the mother were truly HBsAg-positive.

6. **Refer or manage the sexual and household contacts of the pregnant woman with HBV infection.**

HBIG and vaccine are indicated for certain sexual partners and certain household contacts of acute hepatitis B cases (Table 3). HB vaccine is indicated for household and sexual contacts of carriers (Table 3). Screening for susceptibility prior to vaccination should be considered. Medical Assistance and many insurers reimburse for HBIG and vaccine. There is public vaccine for contacts to pregnant women without other sources of funding for these immunizations. Contact your local health department.

REFERENCES

1. Centers for Disease Control. Hepatitis B virus: A comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination; recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1991;40(RR-13):1-25.
2. American Academy of Pediatrics. Report of the Committee on Infectious Diseases (Redbook); 1994:224-38. Elk Grove Village, IL: American Academy of Pediatrics.
3. American College of Obstetricians and Gynecologists. Hepatitis in pregnancy. ACOG Technical Bulletin; Number 174, November 1992. Washington, D.C.: ACOG.
4. American College of Obstetricians and Gynecologists. Immunization during pregnancy. ACOG Technical Bulletin; Number 160, October 1991. Washington, D.C.: ACOG.
5. Beasley RP, Stevens CE, Shiao IS, Meng HC. Evidence against breast-feeding as a mechanism for vertical transmission of hepatitis B. Lancet; 1975; October 18:740-741.
6. DeMartino M, Appendino C, Resti M, Rossi M, et al. Should hepatitis B surface antigen positive mothers breast feed? Arch of Dis in Children 1985;60:972-974.
7. Tseng RYM, Lam CWK, Tam J. Breastfeeding babies of HBsAg-positive mothers. Lancet 1988; October 29:1032.

Table 1. Patterns of Serologic Test Results in Viral Hepatitis A and B

Serology for Patients WITH Acute Hepatitis

If a person presents with signs or symptoms of acute hepatitis and elevated liver enzymes, three serologic tests are needed to distinguish the main types of viral hepatitis.

| HBsAg | Anti-HBcore-IgM | Anti-HAV-IgM | Diagnosis |
|-------|-----------------|--------------|--|
| + | + | — | Early acute hepatitis B |
| — | + | — | Late acute hepatitis B |
| — | — | + | Acute hepatitis A |
| + | — | + | Acute hepatitis A in a HBV carrier |
| — | — | — | Compatible with acute non-A, non-B hepatitis ¹ |
| + | — | — | Compatible with acute non-A, non-B hepatitis in HBV carrier or very early hepatitis B (if total anti-HBcore were positive, it would be more likely to be a HBV carrier; see below) |

Hepatitis B Serology for Patients WITHOUT Acute Hepatitis

| HBsAg | Anti-HBcore-Igm | Anti-HBs | Anti-HBcore (total) | Interpretation |
|-------|-----------------|----------|---------------------|---|
| + | — | — | + | HBV carrier |
| + | — | + | + | HBV carrier with anti-HBs ² |
| — | — | + | + | Immune because of HBV infection |
| — | — | + | — | Immune because of HBV vaccination |
| — | — | — | + | Either: • false positive anti-HBcore, or • passive transfer of antibody, or • low level carrier ³ , or • low level immune ³ |
| — | — | — | — | No infection with HBV (i.e., susceptible) |
| + | — | — | — | Probably false positive HBsAg |

¹ Antibody to hepatitis C virus is not detectable until 3 to 6 months after acute symptoms

² Less than 1% of carriers have HBsAg and anti-HBs in their blood simultaneously

³ Some people with anti-HBcore alone are low level carriers with subdetectable HBsAg, or low level immune with subdetectable anti-HBs

Table 2. Recommended Doses of Currently Licensed Hepatitis B Vaccines

| Age/Status | Vaccine | | | | |
|--|---|--|-------------------------------------|--|---------------------------------------|
| | Recombivax HB ^{a,b} (Merck Sharp & Dohme) | | | Engerix-B ^{a,c} (SmithKline Beecham) | |
| | Pediatric (Brown Cap) 2.5 µg/0.5ml | High-Risk Infant/Adolescent (Yellow Cap) 5 µg/0.5ml | Adult (Green Cap) 10 µg/1.0ml | Pediatric (Blue Cap) 10 µg/0.5ml | Adult (Orange Cap) 20 µg/ 1.0ml |
| Infant born to HBsAg + mother ^{d,e} | | 0.5 ml | 0.5 ml | 0.5 ml | |
| Infant born to HBsAg- mother | 0.5 ml | | 0.25 ml | 0.5 ml | |
| 1-10 years old | 0.5 ml | | 0.25 ml | 0.5 ml | |
| 11-19 years old | | 0.5 ml | 0.5 ml | | 1.0 ml |
| Adult | | | 1.0 ml | | 1.0 ml |

- ^a All vaccines routinely administered in a three-dose series. Engerix-B is also licensed for a four-dose series administered at 0,1,2, and 12 months.
- ^b "If the suggested formulation is not available, the appropriate dose can be achieved from another formulation provided that the total volume of vaccine administered does not exceed 1.0 ml" (Package insert).
- ^c Product is only licensed for use as indicated on the label.
- ^d Infants born to HBsAg positive mothers should receive vaccine and hepatitis B immune globulin (HBIG) within 12 hours of birth; the second and third doses of vaccine are given at 1 and 6 months of age. (See Reference 1.)
- ^e If a mother has **not** been screened prior to delivery, the mother should be screened for HBsAg at the time of delivery. The infant should be given the first dose of vaccine at the dose appropriate for an infant born to a **HBsAg positive** mother and, if the mother's results are HBsAg positive, HBIG should be given within 7 days of birth. Additional doses of vaccine and the schedule will depend on the mother's HBsAg result. (See Reference 1.)

Table 3. Guide to postexposure immunoprophylaxis for exposure to hepatitis B virus

| Type of Exposure | Immunoprophylaxis |
|---|--|
| Perinatal | Vaccination + hepatitis B immune globulin (HBIG) |
| Sexual contact to acute infection | HBIG ± vaccination |
| Sexual contact to chronic carrier | Vaccination |
| Household contact to chronic carrier | Vaccination |
| Household contact to acute case | None unless known exposure |
| Household contact to acute case, known exposure | HBIG ± vaccination |
| Infant (<12 months old) contact to acute case in primary care-giver | HBIG + vaccination |
| Inadvertent-percutaneous /permucosal | Vaccination + HBIG |

Source: Reference 1.

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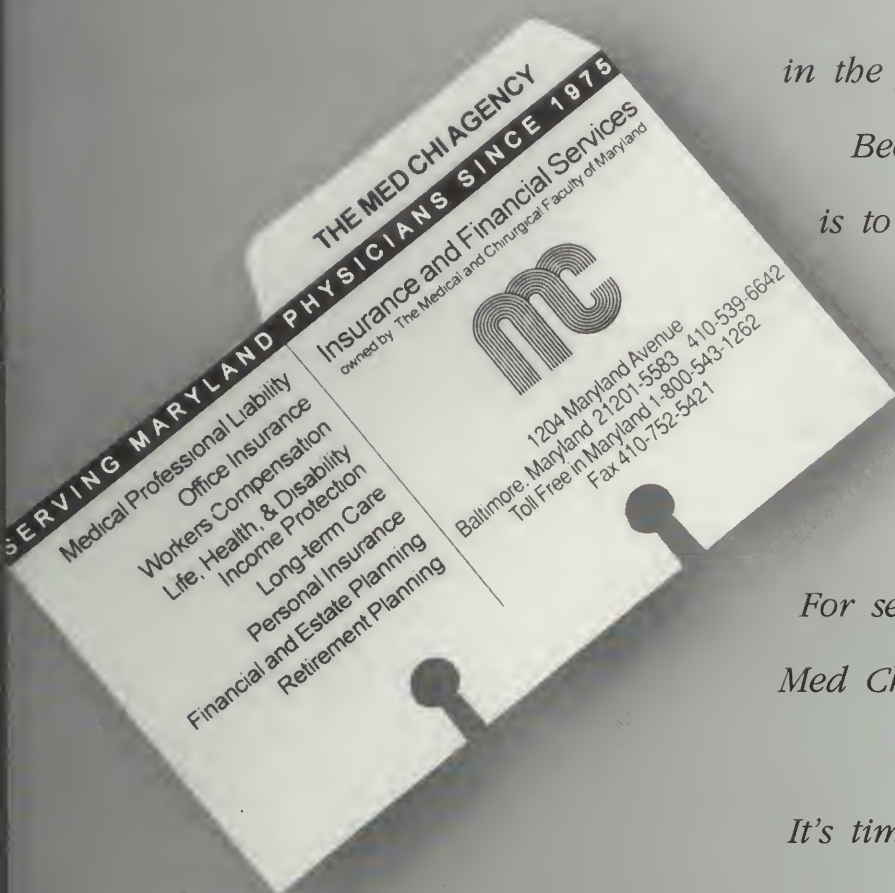
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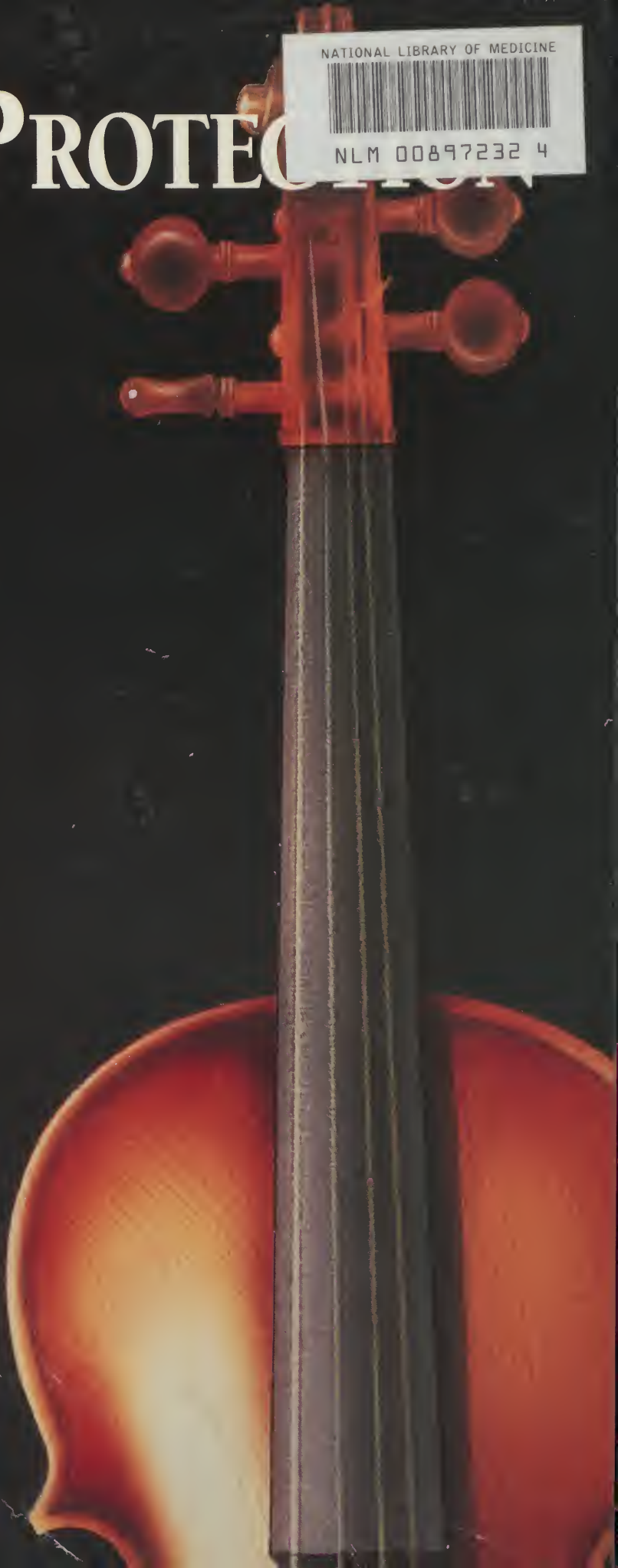
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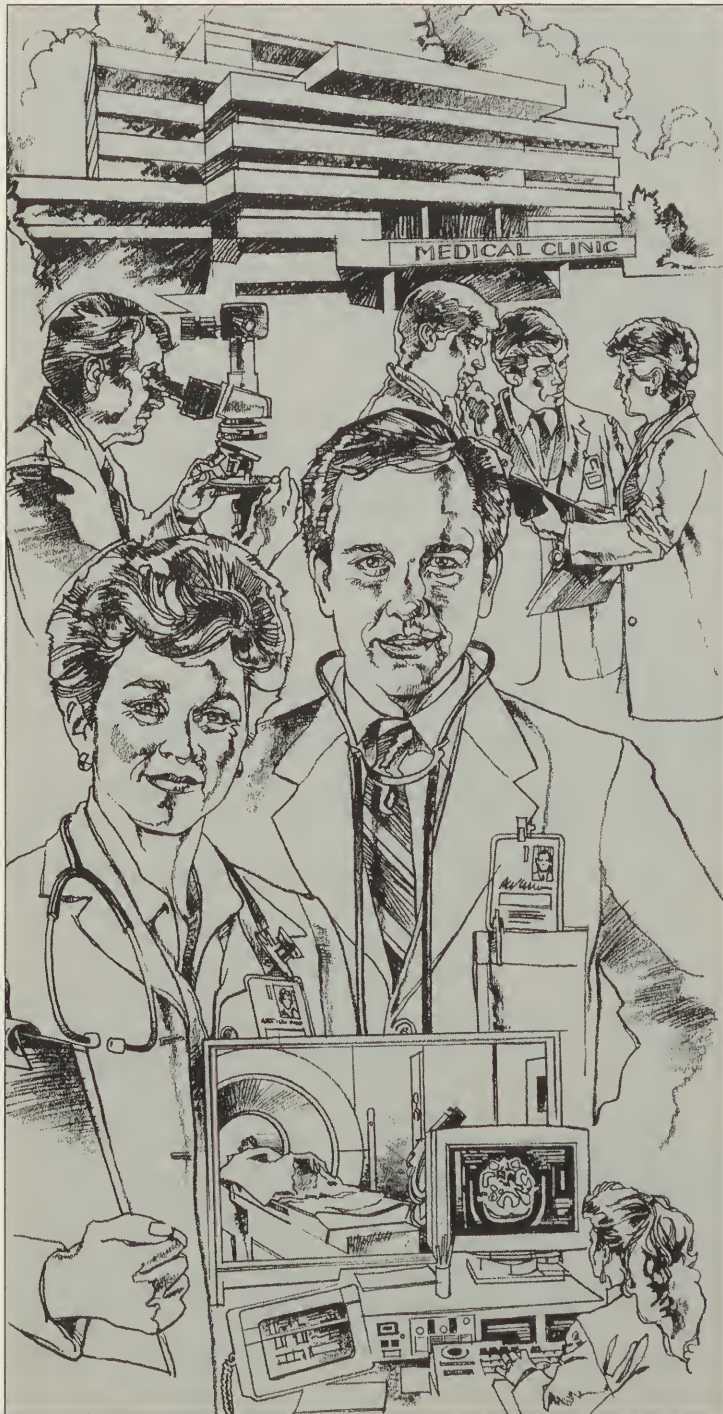
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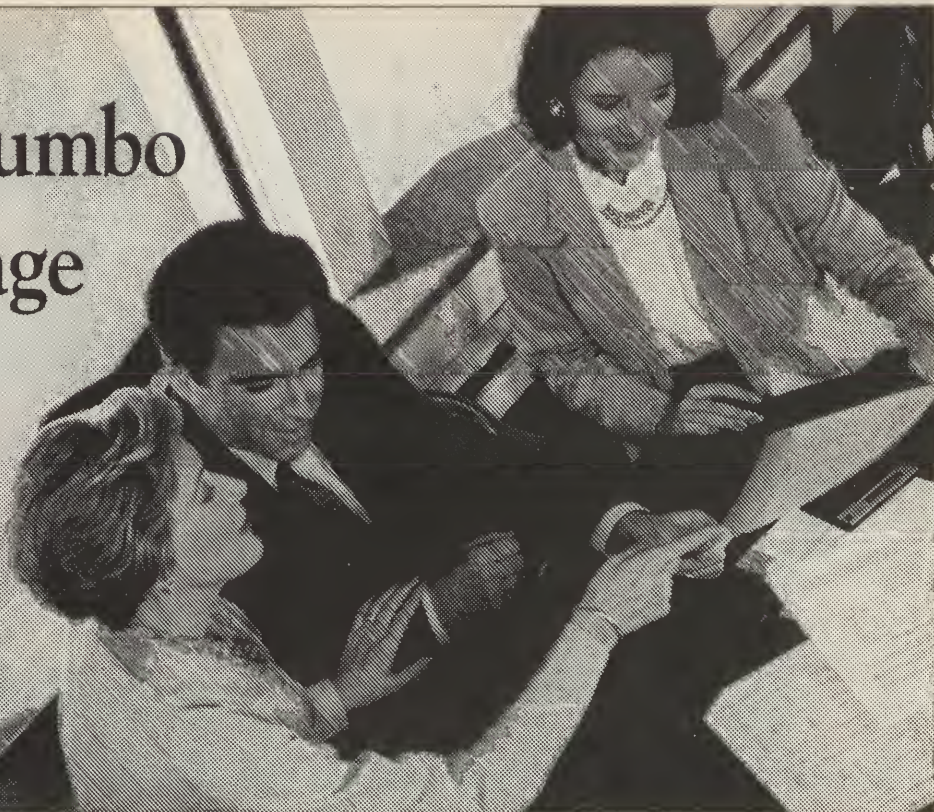
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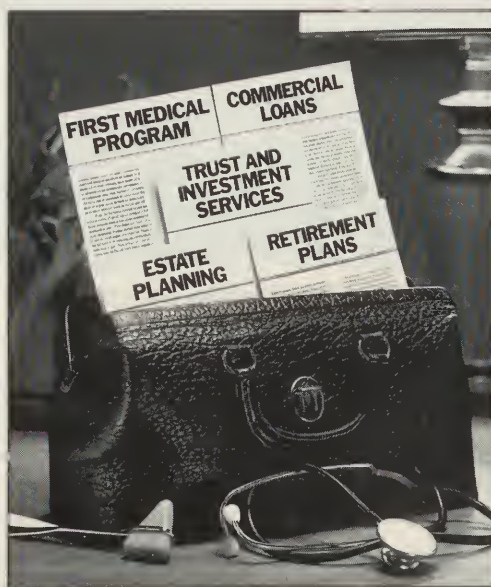
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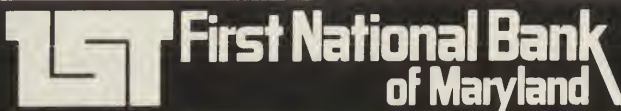


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Chief Executive Officer's Newsletter

December 1994

Dues Notice

This is a reminder to get your dues in as soon as possible. Please note that Maryland Medical Political Action Committee (MMPAC) and American Medical Political Action Committee (AMPAC) dues are for a calendar year, and you are credited for the year in which your dues are received. If you have any questions regarding the dues billing, please call Glen Burger, Med Chi Controller, at 410-539-0872 or 1-800-492-1056, ext. 326. Supporting one's profession is always a positive course of action, and your support is very much appreciated.

Medicare Issues

Flu Shots - Medicare Part B reimburses for the flu vaccine and its administration at 100% of the Medicare allowed charge. Part B deductible and coinsurance do not apply to these charges. Medicare Part B covers the annual administration of the flu vaccine and the allowance is as follows: vaccine (CPT 90724) - \$3.38; administration (HCPCS Q0124) - \$2.67. There is no 5% payment reduction for nonparticipating providers. Physicians may not charge for an office visit if the sole purpose of the patient's visit is to receive the flu vaccine. However, if other services are rendered that may be described by an evaluation and management code, physicians may bill for those services separately.

Medicare beneficiaries who receive shots from physicians who do not accept assignment will be responsible for charges in excess of what Medicare pays.

Medicare Supplier Fraud and Abuse Issues

For prosthetics and orthotics, pick-up and delivery slips are not required (excluding ostomy supplies). The supplier must retain a complete itemization of the specific item(s) being delivered and note the date of delivery. A notation should be made in the progress notes that the beneficiary had received/picked up the item(s). If documentation is requested from the DMERC Fraud and Abuse Unit or from the Medical Review Unit at Medicare, suppliers should include notes indicating that the beneficiary had received the item(s) as billed to Medicare.

The DMERC Fraud and Abuse Unit has received complaints involving suppliers overcharging on **assigned** claims for eyeglass frames and lenses. Fraud investigators have found that suppliers are filing under the standard frame code when deluxe frames are provided or are filing for standard lenses when progressive lenses are provided.

The Fraud unit has suggested that a majority of complaints could be eliminated by suppliers instructing the beneficiary that deluxe frames are not covered by Medicare and that the beneficiary is responsible for the difference in price between the standard and deluxe frame price.

When submitting claims for deluxe frames, code V2020 should be used to report the cost of standard frames and a second line item using code V2025 to indicate the difference between the charges for the deluxe frames and the standard frames should be used.

When billing for progressive lenses, use the appropriate code for the cost of the standard bifocal (V2200-V2299) or trifocal lens (V2300-V2399) and a second line item using code K0162 for the difference between the charge for the progressive lens and the standard lens.

Effective January 1, 1995, Blue Cross and Blue Shield of Texas (BCBSTX) will become the Medicare Part B carrier for Maryland, transitioning from BlueCross BlueShield of Maryland (BCBSMD). BCBSTX will be doing business in Maryland as Trailblazer Health Enterprises, Inc. (THE).

The following dates are provided as the cutover schedule for providers from BCBSMD to THE:

- | | | | | | | | |
|--------------------------------|---|-------------------------------|---------------------------------------|----------------------|----------------------|--------------------------------|--------------------------------|
| 12/06/94 | BCBSMD begins elimination of the payment floor for both paper and EMC claims. | | | | | | |
| 12/15/94 | Last day BCBSMD will accept paper claims or correspondence in mailroom. | | | | | | |
| 12/16/94 | Last day BCBSMD will accept electronic claims. | | | | | | |
| 12/16/94 | Last day for original paper claim entry at BCBSMD. Providers should begin mailing paper claims and correspondence to THE: <table border="0"><tr><td>Medicare Part B Claims</td><td>Medicare Part B Correspondence</td></tr><tr><td>P.O. Box 5678</td><td>P.O. Box 5798</td></tr><tr><td>Timonium, MD 21094-5678</td><td>Timonium, MD 21094-5798</td></tr></table> | Medicare Part B Claims | Medicare Part B Correspondence | P.O. Box 5678 | P.O. Box 5798 | Timonium, MD 21094-5678 | Timonium, MD 21094-5798 |
| Medicare Part B Claims | Medicare Part B Correspondence | | | | | | |
| P.O. Box 5678 | P.O. Box 5798 | | | | | | |
| Timonium, MD 21094-5678 | Timonium, MD 21094-5798 | | | | | | |
| 12/19/94 to 12/31/94 | First day that THE will accept electronic claims from Maryland providers. (Providers submitting electronic claims through Maryland Health Information Network (MHIN) should continue submitting claims to MHIN. Providers currently submitting electronic claims directly to BCBSMD should submit claims directly to THE.) EMC submitted claims will be held by THE until the January 3 claims payment cycle. EMC acceptance reports will go to submitters daily. | | | | | | |
| 12/19/94 to 12/31/94 | Paper claims will be keyed by THE and held for processing until 1/3/95. | | | | | | |
| 12/20/94 | Last day for claim payment by BCBSMD. All claims to be released from floor. Last day for crossover to other insurers by BCBSMD. | | | | | | |
| 12/30/94 | Last day by BCBSMD for phone and lobby service for beneficiaries/providers. | | | | | | |
| 01/03/95 | THE to begin claims payment cycle. The payment floor will be reinstituted gradually. | | | | | | |
| 01/03/95 | THE begins customer service for beneficiaries/providers. | | | | | | |
| 01/16/95 | Full payment floor in place by THE. | | | | | | |

*THE Hires Medical
Director and
Operations Director*

Trailblazer Health Enterprises, Inc. (THE) has announced the hiring of Marco Riisager, M.D., who will be the full-time medical director for Medicare Part B in Maryland (except for Prince George's and Montgomery counties). Dr. Riisager was formerly the medical director of BlueCross BlueShield of Florida.

THE has also announced the hiring of David Vaughn as the director of Medicare operations. Mr. Vaughn was previously employed as the director of information services division, Medicare Part B, Hartford, Connecticut.

CLIA Information

The Commission on Office Laboratory Accreditation (COLA) in Silver Spring, Maryland (800-298-8044) is a private, nonprofit educational and accreditation

program for physician office labs. To prepare labs for Clinical Laboratory Improvement Amendments (CLIA) inspections, COLA has developed a 299-question, self-administered questionnaire. Furthermore, nearly 6,000 physician office labs have enrolled in COLA's accreditation program, which is recognized by the Health Care Financing Administration (HCFA). Sources indicate that COLA inspections cost less than HCFA inspections.

To obtain HCFA's CLIA inspection manuals, which include survey procedures and interpretive guidelines to help prepare for inspections, call the National Technical Information Service at 800-553-6847 and ask for PB92146174 and PB93950012.

The Medical Group Management Association provides "Directions: Quality Assurance Manual for Physician Office Laboratories." Call 303-397-7888 to obtain a copy.

***BlueCross BlueShield
of Maryland
Announces New Fee
Schedule***

On November 9, 1994, over 75 physicians, representing component and specialty medical societies, attended a Managed Care Committee meeting at Med Chi to learn about Maryland BlueCross BlueShield's (BCBS) transition to a new fee schedule. Mrs. Debbie Holloway, vice president of network management for BCBS, assisted by Daniel McCrone, M.D., vice president and indemnity medical director for BCBS, explained that Maryland's largest insurer plans to **lower payments for medical services** by converting to a resource-based relative value scale (RBRVS) system.

Mrs. Holloway reported that BCBS, in order to be competitive in today's market, had to file several rate decreases with the Insurance Commission in terms of premiums. The recent rate decrease filed by the insurer was called forward pricing, which assumes that the insurer is going to achieve cost reductions that will enable it to do business with that type of pricing in the market.

Mrs. Holloway said BCBS would achieve these savings by reducing its administrative expenses, and hospitals and providers would also be expected to contribute. Hospital payments will be reduced through a program called integrated health management (IHM), which consists of concurrent review and case management on indemnity patients. Providers will be transitioned to an RBRVS system that will provide greater reductions to practices heavily oriented toward procedures. A few specialties (dermatology, family practice, internal medicine, pediatrics) are expected to see an increase in payments, while the majority of specialties will see a decrease. For example, BCBS's "Sample Summary of Fee Schedule Impact" lists the following **payment decreases** based on field of practice:

| | | | |
|------------------------|--------|----------------------|--------|
| cardiovascular disease | 24.53% | ophthalmology | 8.76% |
| emergency medicine | 11.90% | orthopedic surgery | 15.10% |
| gastroenterology | 23.31% | otology, laryngology | 15.28% |
| general surgery | 16.34% | physical therapy | 7.84% |
| OB/GYN | 11.63% | radiology | 22.23% |

The exact decrease in payments for specific practices, however, will depend on the type of practice, the current charge for services, and whether the practice provides mostly cognitive services or does procedures.

Although Mrs. Holloway and Dr. McCrone stressed that BCBS had to transition to a fee schedule to prepare for the changes under H.B. 1359, which require the

Health Care Access and Cost Commission (HCACC) to develop a fee schedule, it appeared that the schedule developed by BCBS bore little resemblance to the fee schedule being developed by HCACC.

With approximately 11,000 provider contracts already signed, physicians questioned why BCBS was introducing a fee schedule at this time. Concern was expressed that the decrease in payments was an attempt by BCBS to reduce its panel of providers. Both Mrs. Holloway and Dr. McCrone assured the physicians that it was their sincere hope that providers would not drop from the BCBS network.

Physicians concerned about the recent trend to adopt easy solutions to the insurance crisis by arbitrarily cutting payments to providers, noted that **physicians have not seen a general increase in physician profiles by BCBS since 1985**. However, physicians are being told their fees will be reduced without documentation and that their fees have contributed to BCBS's current problem of not being able to be competitive. It was noted that BCBS's subscriber premiums have risen continuously over the last several years and that corporate mismanagement has led to many of the problems being experienced by BCBS. Mrs. Holloway said she could not change the past, but that BCBS was trying diligently to manage better in the future.

Mrs. Holloway specifically pointed out that BCBS is the only insurance provider in Maryland that has an open panel allowing any willing provider to contract with it. Mrs. Holloway cautioned that if BCBS cannot remain competitive in the market, Maryland may see indemnity plans extinguished in the state.

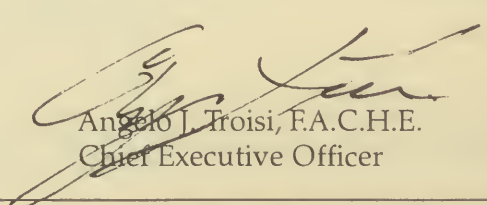
Med Chi will continue to monitor the new BCBS fee schedule and work closely with the component and specialty medical societies to address any concerns or issues raised by physicians.

HIV Telephone Consultation Service

Physicians in need of clinical information on HIV can call the HIV Telephone Consultation Service, a toll-free service sponsored by the AIDS Education and Training Centers in the Health Resources and Services Administration and by the American Academy of Family Physicians. The service, which is staffed by faculty physicians, nurse-practitioners, and pharmacists at San Francisco General Hospital, is intended for use by health care providers only. The service can be reached at 1-800-933-3413 during business hours Monday through Friday.
(Source: *Pediatric News*, October 1994)

Newborn Baby AIDS Vaccine Program

The AIDS Clinical Trials Unit of the Johns Hopkins Children's Center is testing the safety of AIDS vaccines and their ability to stimulate the immune system in newborn babies. The goal of the program is to reduce the number of babies who contract HIV from their mothers. However, the goal has been hindered by the difficulty in recruiting women willing to participate in the trials. Call 410-955-SAVE for additional information on the AIDS vaccine trials for newborns.



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Members in the News



WILLIAM A. CRAWLEY, D.D.S., M.D., F.A.C.S., an associate professor of plastic surgery at The Johns Hopkins Medical Institutions, has been appointed to the State Board of Physician Quality Assurance. A native of Texas, Dr. Crawley completed his undergraduate education at Texas Christian

University in Fort Worth and received his dental degree from Baylor College of Dentistry in Dallas. After earning his medical degree at The Johns Hopkins University School of Medicine in Baltimore, he completed residencies in oral, general, and plastic surgery at The Johns Hopkins Hospital and was awarded a fellowship in microvascular surgery at the Ralph K. Davies Medical Center in San Francisco. Dr. Crawley, a diplomate of the American Board of Plastic Surgery, Inc., is a member of numerous professional societies, including the American Society of Maxillofacial Surgeons (of which he is secretary), American Society of Plastic and Reconstructive Surgeons, Association of Academic Chairmen of Plastic Surgery, American College of Surgeons, and American Medical Association. He is president of the John Staige Davis Society of Plastic Surgeons of Maryland, Inc., and a member of the Medical Specialist Identification Committee of Med Chi.



BENJAMIN M. FRISHBERG, M.D., an assistant clinical professor at George Washington University, received a 1994 honor award from the American Academy of Ophthalmology. Board certified in psychiatry and neurology, Dr. Frishberg is in the private practice of neurology in Chevy Chase. He received his bachelor of arts degree summa

cum laude from the University of Minnesota and his medical degree from the University of Minnesota Medical School. In addition to completing residencies in internal medicine and neurology, he was a visiting fellow in pediatric neuromuscular disease at the Royal Postgraduate Medical School in London and a fellow in neuro-ophthalmology at Emory University School of Medicine in Atlanta. He is a fellow of the American Academy of Neurology and the North American Neuro-ophthalmology Society.



J. LEONARD LICHTENFELD, M.D., a Baltimore internist and instructor at The Johns Hopkins University School of Medicine, was re-elected secretary-treasurer of the American Society of Internal Medicine. He received his undergraduate degree from the University of

Pennsylvania and his medical degree from Hahnemann Medical College in Philadelphia. Certified by the American Board of Internal Medicine and a fellow of the American College of Physicians, Dr. Lichtenfeld is a past president of the Maryland Society of Internal Medicine. In addition to having served as a physician reviewer for the President's Task Force on Health Care Reform, he is a member of a physician panel that is developing mammography guidelines for the Agency for Health Care Policy and Research. Dr. Lichtenfeld also serves on Med Chi's Family Violence Task Force and HMO Quality and Practice Parameters Technical Advisory Committee.



IBRAHIM A.A. RAZZAK, M.D., head of gastroenterology at Greater Baltimore Medical Center, was re-elected governor of the American College of Gastroenterology. Dr. Razzak, who received his medical degree from Ein Shams University School of Medicine in Cairo, Egypt, completed his

residency in internal medicine at GBMC and a fellowship in gastroenterology at Baltimore City Hospitals/Johns Hopkins Medical Institutions. He is a clinical assistant professor in the department of medicine at the University of Maryland School of Medicine and an instructor in the department of medicine at The Johns Hopkins School of Medicine. President of the Maryland Society for Gastrointestinal Endoscopy, Dr. Razzak is a fellow of the American College of Gastroenterology, American College of Physicians, and Royal College of Physicians of Edinburgh.

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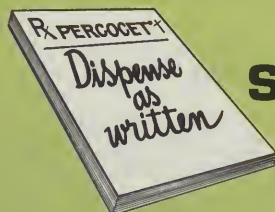
You may avoid pain by providing adequate time-contingent dosing to prevent breakthroughs rather than subduing them¹.

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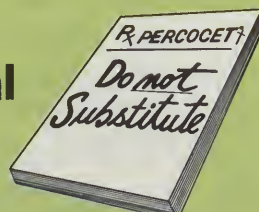
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REFERENCE:

1. Acute Pain Management Guidelines Panel. *Acute Pain Management in Adults: Operative Procedures. Quick Reference Guide for Clinicians*. AHCPR Pub. No 92-0019, pg. 12. Rockville, Md: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.

BRIEF SUMMARY

PERCOCET® (Oxycodone (WARNING: may be habit forming) and Acetaminophen Tablets, USP)

INDICATIONS AND USAGE PERCOCET is indicated for the relief of moderate to moderately severe pain.

CONTRAINDICATIONS PERCOCET should not be administered to patients who are hypersensitive to oxycodone or acetaminophen.

WARNINGS **Drug Dependence:** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET is subject to the Federal Controlled Substances Act (Schedule II).

PRECAUTIONS **General:** *Head Injury and Increased Intracranial Pressure:* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of PERCOCET or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special Risk Patients: PERCOCET should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Information for Patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET should be cautioned accordingly.

Drug Interactions: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with oxycodone preparations may increase the effect of either the antidepressant or oxycodone.

The concurrent use of anticholinergics with narcotics may produce paralytic ileus.

Usage in Pregnancy Pregnancy Category C: Animal reproductive studies have not been conducted with PERCOCET. It is also not known whether PERCOCET can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. PERCOCET should not be given to a pregnant woman unless in the judgment of the physician, the potential benefits outweigh the possible hazards.

Nonteratogenic Effects: Use of narcotics during pregnancy may produce physical dependence in the neonate.

Labor and Delivery: As with all narcotics, administration of PERCOCET (oxycodone and acetaminophen tablets, USP) to the mother shortly before delivery may result in some degree of respiratory depression in the newborn and the mother, especially if higher doses are used.

Nursing Mothers: It is not known whether PERCOCET is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when PERCOCET is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS The most frequently observed adverse reactions include lightheadedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus. At higher doses, oxycodone has most of the disadvantages of morphine including respiratory depression.

DRUG ABUSE AND DEPENDENCE PERCOCET (oxycodone and acetaminophen) Tablets are a Schedule II controlled substance.

Oxycodone can produce drug dependence and has the potential for being abused. (See WARNINGS.)

OVERDOSAGE **Acetaminophen Signs and Symptoms:** In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma and thrombocytopenia may also occur.

In adults, hepatic toxicity has rarely been reported with acute overdoses of less than 10 grams and fatalities with less than 15 grams. Importantly, young children seem to be more resistant than adults to the hepatotoxic effect of an acetaminophen overdose. Despite this, the measures outlined below should be initiated in any adult or child suspected of having ingested an acetaminophen overdose.

Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Treatment: The stomach should be emptied promptly by lavage or by induction of emesis with syrup of ipecac. Patient's estimates of the quantity of a drug ingested are notoriously unreliable. Therefore, if an acetaminophen overdose is suspected, a serum acetaminophen assay should be obtained as early as possible, but no sooner than four hours following ingestion. Liver function studies should be obtained initially and repeated at 24-hour intervals.

The antidote, N-acetylcysteine, should be administered as early as possible, preferably within 16 hours of the overdose ingestion for optimal results, but in any case, within 24 hours. Following recovery, there are no residual, structural, or functional hepatic abnormalities.

Oxycodone Signs and Symptoms: Serious overdosage with oxycodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride (Narcan®) is a specific antidote against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of naloxone hydrochloride (usual initial adult dose 0.4 mg to 2 mg) should be administered preferably by the intravenous route, and simultaneously with efforts at respiratory resuscitation (see package insert). Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.

Gastric emptying may be useful in removing unabsorbed drug.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET (oxycodone and acetaminophen tablets) is given orally. The usual adult dosage is one tablet every 6 hours as needed for pain.

HOW SUPPLIED PERCOCET (5 mg oxycodone hydrochloride and 325 mg acetaminophen tablets, USP), supplied as a white tablet, with one face scored and inscribed PERCOCET, and the other inscribed with DuPont name is available in:

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The Chest Pain Evaluation Center at the University of Maryland Medical Center

Robert J. Doherty, M.D., F.A.C.E.P., Robert A. Barish, M.D., F.A.C.E.P., F.A.C.P.,
and Georgina Groleau, M.D., F.A.C.E.P., F.A.C.P.

From the division of emergency medicine, department of surgery, University of Maryland Medical Center, Baltimore, where Dr. Doherty is a co-director of the Chest Pain Evaluation Center, Dr. Barish is director of emergency medical services, and Dr. Groleau is director of quality assurance programs.

Ischemic heart disease, the leading cause of death in the United States, accounts for 448 deaths per 100,000 people annually.¹ Acute myocardial infarction (MI) continues to be a common clinical presentation in emergency departments. Conservative estimates indicate that 675,000 acute MIs occur each year in this country, 80% of which are first seen in hospital emergency departments.²

Strategies in the approach to patients with ischemic heart disease have evolved over several decades. In the 1950s, before the development of coronary care units, the mortality rate associated with acute MI was 30%. Beginning in the 1960s and continuing into the 1970s, the rate fell to approximately 15% in association with the opening of coronary care units and increasing sophistication in acute cardiac care. Advances in thrombolytic therapy during the 1980s further decreased mortality to near 5%. The impact of chest pain centers, the coronary care innovation of the 1990s, remains to be seen, but their emphasis on effective emergency department evaluation for underlying coronary artery disease is expected to reduce long-term morbidity and mortality.

Detection of acute MI and ischemic heart disease in the emergency department remains problematic. An estimated 2.5 million emergency department visits per year are prompted by "chest pain." Traditional "rule-out" strategies cost approximately \$8 billion. Despite the depth of clinical involvement suggested by such expense, MIs continue to be "missed" during emergency department evaluations. In 1976, Schor³ reported that 7.7% of patients who presented with chest pain were discharged from the emergency department inappropriately—they had an MI shortly after discharge. In a similar study published in 1987, Lee⁴ found an inappropriate discharge rate of 3.8%, and in 1993, McCarthy⁵ showed a rate of 1.9%. Although it is clear that emergency department evaluation of chest pain has improved, a missed MI rate of nearly 2% is an area of concern. Missed MIs in the emergency

department are the basis for the largest dollar loss in emergency medicine malpractice claims. In Massachusetts for example, between 1980 and 1988, only 7% of filed claims dealt with MI, yet 21% of all dollars lost related to those cases.⁶

Emergency department presentations of acute chest pain cover a broad spectrum. Decisions regarding admission or discharge are formidable clinical challenges affected by multiple considerations. Patients have complex histories encompassing familial predisposition to heart disease, cigarette use, and personal medical status. Diagnostic resources vary from center to center. In crowded urban hospitals, the availability of appropriate beds for monitoring cardiac patients can be a limiting factor. Too often, patients who are discharged rapidly following "rule out" without thorough cardiac testing return to the emergency department with the same complaint. In this environment, new approaches to the assessment and treatment of patients with chest pain obviously are needed.

Development of chest pain centers

By 1993, at least 300 hospitals in the United States had opened chest pain centers.² The first such center in the country opened in 1988 at St. Agnes Hospital in Baltimore.^{7,8} Under the direction of Dr. Raymond Bahr, the chest pain emergency department was developed as a dedicated emergency department area and a specific emergency department system for patients with acute chest pain. Included in that system are extensive cardiac outreach educational programs and extensive cardiac-specific quality assurance programs within the entire hospital. Many centers have followed the Bahr model; some have expanded it.

One of the major academic chest pain centers is at the University of Cincinnati Medical Center.⁹ Within this dedicated emergency department area, specific standardized protocols are applied to all chest pain patients in the emergency department. Following an initial observation period, patients with ischemic heart events receive prompt emergency department-based cardiology consultation and prompt cardiac testing, usually including an echocardiogram (ECHO) and exercise treadmill test (ETT). The resulting evaluation is more complete and comprehensive, providing better information to physicians as well as patients.

Chest pain centers across the United States hold several principles in common. First is an overall dedication to enhanced emergency department evaluation and treatment of ischemic heart disease. The specific goal is rapid detection of acute MI and rapid application of a systematic approach that allows thrombolytic therapy to be initiated as quickly as possible. This emergency department dedication extends to the evaluation of patients with acute chest pain who do not appear to be having an

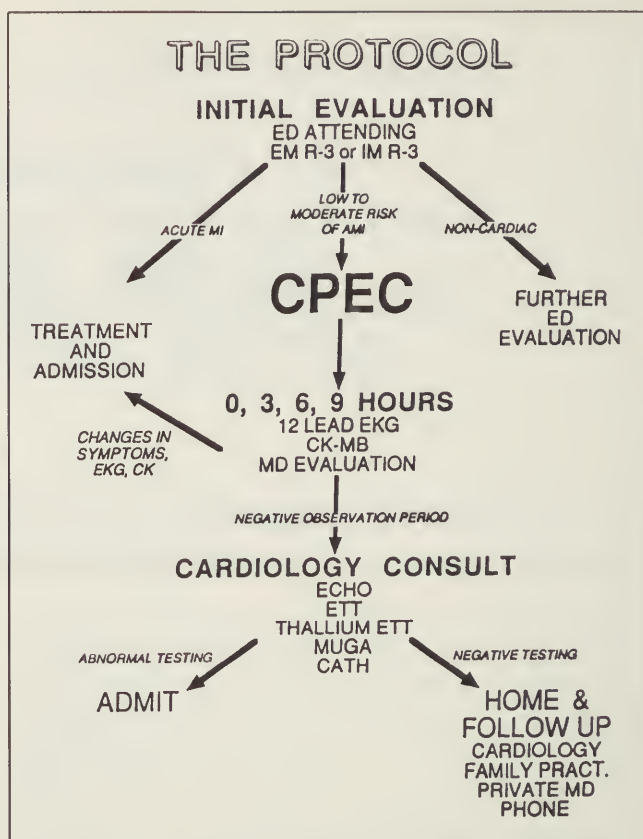


Figure 1. Algorithm for emergency department evaluation, treatment, and disposition of patients with chest pain.

acute MI. The second major principle is emphasis on public education about the early recognition of acute cardiac symptoms.¹⁰ The public is encouraged to seek medical evaluation for vague discomfort, with the hope that the development of acute MI can be avoided. The responsibility for educational programs is shared by the hospital and civic groups. The third principle is emphasis on increased and efficient utilization of hospital resources for cardiac evaluation. Specifically, noninvasive cardiac testing, ETT, and cardiac catheterization must be readily available to the emergency department.

The Chest Pain Evaluation Center at the University of Maryland Medical Center

The Chest Pain Evaluation Center (CPEC) at the University of Maryland Medical Center, which opened in 1993, is a combined effort of the divisions of emergency medicine and cardiology. In addition, the CPEC relies on the medical center's clinical laboratory for accurate clinical marker assays with rapid turnaround. The goal is to evaluate patients promptly and cost effectively for both cardiac ischemia and coronary artery disease while meeting the clinical sensitivity these diseases warrant. The unit is designed to provide thorough and appropriate evaluation of patients who would routinely be admitted to the hospital from the emergency department.

The physical environment of the CPEC was designed carefully. It is contiguous with, yet separate from, the emergency department to offer a quiet, comfortable area for patients. Technology for arrhythmia and ST segment analysis is integral to the assessment bays. In addition, ready access to the clinical laboratory (stat lab) minimizes the time necessary for obtaining assay results.

The CPEC protocol is shown in **Figure 1**. A patient who arrives at the emergency department (on foot, by car, or in an ambulance) with acute chest pain receives an initial triage evaluation by a nurse and is brought rapidly to the treatment area. Notification of the patient's arrival is given to the senior physician, who performs the initial evaluation. The patient's eligibility for the CPEC is determined according to presenting history, symptoms, risk factors, physical examination, and electrocardiographic tracing. Information is gathered via protocol and collected on history and physical examination forms designed specifically for the unit (**Figure 2**).

Patients clearly at high risk (with classic signs and symptoms of acute MI) and those clearly at low risk (e.g., with musculoskeletal or gastrointestinal complaints) are excluded. Appropriate for the CPEC are the typical problematic patients whose symptoms strongly suggest MI but whose workup is negative (often called the "soft rule out"). Patients deemed appropriate for the unit are admitted to the CPEC for a rule-out observation period. Staff physicians and nurses inform the patient of the ensuing treatment plan. At hours 3, 6, and 9, the electrocardiogram (ECG), physical examination, and creatine kinase and isoenzyme MB (CKMB) assay are repeated. If there are no indications of cardiac ischemia during the observation period, the patient is seen promptly by a cardiology consultant. The emergency department staff, in conjunction with the cardiology staff, then conducts a diagnostic evaluation appropriate for that patient. If all evaluations are negative, the patient is discharged with specific follow-up instructions. If any abnormalities are detected during the observation or evaluation, the patient is admitted to an inpatient unit.

The difficulties inherent in emergency department evaluation of chest pain, and the utility of the CPEC protocol, are demonstrated in the following scenarios.

Case 1. A 56-year-old woman presented to the emergency department with pain on her left side. She stated that she had experienced a 30-minute episode of discomfort radiating to her left arm. On arrival, she was not in pain, the symptoms having resolved spontaneously. The patient's history included diabetes mellitus, hypertension, and anxiety disorder. Results of the physical examination, laboratory tests, ECG, and chest radiography were all within normal limits.

The patient's risk factors raised some concern about acute MI, but the initial evaluation was noncontributory. She was admitted to the CPEC, where acute MI was ruled out during the 9-hour observation period. A repeat ECHO was within normal limits. During an ETT, abnormalities associated with angina and ischemic changes were detected. Based on those indicators, the patient was taken to the catheterization laboratory shortly thereafter, where assessment showed normal coronary arteries. The patient was discharged with instructions to be seen in cardiology follow-up for further treatment of her hypertension and medical condition.

Case 2. A 28-year-old man presented with chest pain of new onset. He reported that he was visiting a college roommate for the weekend and had smoked crack cocaine during the visit (chest pain following cocaine use is a common complaint in urban emergency departments). Approximately 30 minutes before arriving at the emergency department, he developed mid-sternal chest tightness. He had no underlying medical risk factors. Physical examination, laboratory assays, and chest films were within normal limits. The ECG showed diffuse J-point elevation, but it was not clear whether this was early repolarization or a potential injury pattern.

The patient was admitted to the CPEC. CK level was marginally elevated, but isoenzyme MB assays showed no elevation. An ECHO was within normal limits. After consultation with a cardiologist, the emergency physician determined that an ETT would not be helpful in the evaluation. The patient was discharged from the CPEC within 13 hours of initial presentation. He was given copies of his records and advised to obtain a follow-up evaluation with his personal physician in his home state.

Case 3. A 64-year-old woman had been treated at a private physician's office for complaints of progressive angina. At that office, she had received nitroglycerin and was referred to the CPEC. She had a 1-month history of increasing dyspnea and chest pain associated with exertion. Shortly before arriving at the emergency department, she had two episodes of chest pain with diaphoresis and dyspnea that resolved after administration of nitroglycerin. Through consultation with the primary care physician, the emergency physician learned that an ECG obtained at the private office showed anterior ST depression with pain (the tracing was not sent with the patient). Risk factors included obesity, diabetes mellitus, hypertension, smoking, and elevated cholesterol. Physical examination, laboratory testing, and chest films were all within normal limits. On arrival, the patient's symptoms had resolved and her ECG was normal.

Shortly after admission, the patient had recurrent chest pain with ST segment changes on monitor. She was admitted promptly to the coronary intensive care unit, where a non-Q-

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CARDIAC TESTING

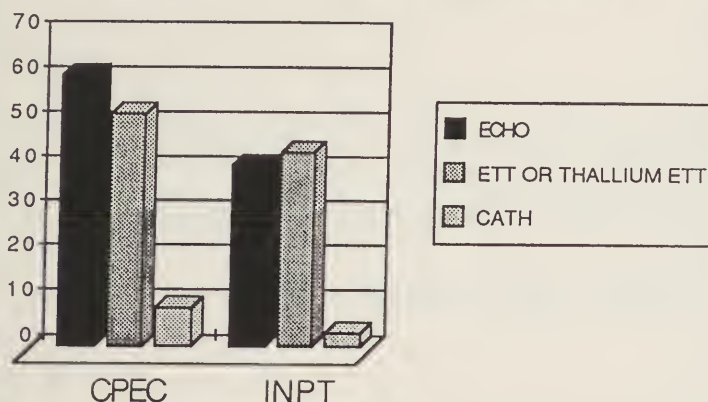


Figure 3. Comparison of cardiac testing used in 226 patients treated in the Chest Pain Evaluation Center (CPEC) and 67 patients admitted directly to an inpatient (INPT) unit at the University of Maryland Medical Center. CPEC patients were more likely to be evaluated with echocardiography (ECHO), exercise treadmill test (ETT) or thallium ETT, or cardiac catheterization; however, the cost of CPEC evaluation was much lower than inpatient care, primarily because length of stay was reduced dramatically (see text).

wave MI was diagnosed. A coronary artery bypass graft was performed several days later.

Case 4. A 56-year-old man presented with new chest pain. He described a 45-minute episode of chest tightness that was now resolved. He also stated that he had a 1-month history of exertional "indigestion." Risk factors included smoking, hypertension, and a strong family history of heart disease. The physical examination, laboratory tests, ECG, and chest films were within normal limits.

During the 9-hour observation, MI was ruled out. An ECHO was normal, but the ETT was markedly abnormal. The patient was taken to the catheterization laboratory promptly, where a left anterior descending artery lesion was detected. He was treated with percutaneous transluminal coronary angioplasty.

CPEC impact: preliminary results

During the first 9 months of the CPEC's operation, data were collected prospectively on all patients seen in the unit. For comparison, data were evaluated from patients admitted to the University of Maryland Medical Center for a traditional MI "rule out." In general, comparison patients were admitted directly from medical clinics or referred by private physicians for admission and therefore were not eligible for the preliminary CPEC evaluation protocol.

The number of patients seen in the CPEC over the study period totalled 226; 67 comparison patients were admitted during that time. The mean ages of the groups were 50.3 years and 53.4 years, respectively. Women predominated in the

CPEC population (58.4%) and men among the inpatients (55.2%).

The use of cardiac testing is shown in **Figure 3**. The data indicate that CPEC patients received more complete evaluations than inpatients. A higher percentage of patients treated in the CPEC were evaluated with noninvasive measures (ECHO and ETT).

Inpatient stays averaged 52.8 hours (2.2 days) compared with an average of 17.4 hours in the CPEC, which included the initial 9-hour observation period and time needed for cardiac testing. (Patients with acute MI admitted to the critical care unit from the CPEC are excluded from these calculations.) The total charge for an inpatient stay was almost three times greater than the total charge for CPEC evaluation (for ECGs, laboratory work, radiology, and nursing and technicians' fees).

Of the 226 CPEC patients, 176 (78%) were discharged home from the unit and 50 (22%) were admitted to the hospital for cardiac or other medical

problems. Ischemic heart disease was ultimately diagnosed in approximately 2% of the CPEC patients. No patient has been identified as having an adverse outcome after being discharged from the CPEC.

Conclusions

Preliminary data indicate that the CPEC at the University of Maryland Medical Center provides a more complete assessment of patients with acute chest pain in less time, with higher utilization of noninvasive testing, and at lower cost than the inpatient unit.

In Maryland, there are research-oriented chest pain centers at the University of Maryland Medical Center and St. Agnes Hospital. A number of other medical facilities in the Baltimore metropolitan area have contacted the University of Maryland CPEC regarding the development of additional centers. Such advances are supported and encouraged.

Future directions for the CPEC include extensive evaluation of patient data for patterns in coronary artery disease in the Baltimore area. Research initiatives will focus on the utility of acute echocardiography at emergency department presentation, evaluation of stress echocardiography, and methods of selecting patients who may benefit from immediate cardiac catheterization rather than initial noninvasive workup.

References

1. Trends in ischemic heart disease mortality—United States, 1980-1988. *MMWR Morb Mortal Wkly Rep* 1992;41:548.

2. Shesser R, Smith M. The chest pain emergency department and the outpatient chest pain evaluation center: revolution or evolution? *Ann Emerg Med* 1994;23:334-341.
3. Schor S, Behar S, Modan B, Barell V, Drory J, Kariv I. Disposition of presumed coronary patients from an emergency room: a follow-up study. *JAMA* 1976;236:941-943.
4. Lee TH, Rouan GW, Weisberg MC, Brand DA, Acampora D, Stasiulewicz C, et al. Clinical characteristics and natural history of patients with acute myocardial infarction sent home from the emergency room. *Am J Cardiol* 1987;60:219-224.
5. McCarthy BD, Beshansky JR, D'Agostino RB, Selker HP. Missed diagnoses of acute myocardial infarction in the emergency department: results from a multicenter study. *Ann Emerg Med* 1993;22:579-582.
6. Karcz A, Holbrook J, Burke MC, Doyle MJ, Erdos MS, Friedman M, et al. Massachusetts emergency medicine closed malpractice claims: 1988-1990. *Ann Emerg Med* 1993;22:553-559.
7. Bahr RD. Hospital efficiency in early coronary care. *Md State Med J* 1987;36:433-434.
8. Bahr RD. Early cardiac care centers. *Circulation* 1989;79:463.
9. Gibler WB, Walsh RA, Levy RC, et al. Rapid diagnostic and treatment centers in the emergency department for patients with chest pain. *Circulation* 1992;86(suppl 1):1-15.
10. Bahr RD. Access to early cardiac care: chest pain as a risk factor for heart attacks, and the emergence of early cardiac care centers. *Md Med J* 1992;41:133-137.

Acknowledgments

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Hospital and emergency medical services system interaction during the implementation of chest pain emergency rooms

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ABSTRACT: *Knowledgeable personnel at 23 hospitals with chest pain emergency rooms (CPERs) served by nonhospital-based emergency health services (EMS) systems were surveyed. Although few hospitals had involved EMS in the planning stages of the CPER, there were no reports of a poor relationship with the local EMS system, and surveyed personnel perceived neither deterioration nor improvement in their hospital's relationship with EMS after opening the CPER. Hospitals where EMS was considered important to the functioning of the CPER were significantly more likely to have involved EMS in the CPER planning process.*

Raymond Bahr, M.D., of St. Agnes Hospital in Baltimore, Maryland, developed the concept of the chest pain emergency room (CPER)¹ to provide quick response to patients presenting with either classic symptoms of ischemic heart disease or less pronounced symptoms commonly seen during the prodromal phase of an ischemic event. Because patients are seen quickly, definitive therapy can be started during the critical early stages of a myocardial infarction. A number of hospitals have now developed CPERs and associated emergency cardiac care systems (ECCS).

There are many causes of delay in seeking treatment for symptoms of ischemic heart disease.^{2,3} To address the delay, Dr. Bahr formulated ECCS, a community outreach program designed to raise public awareness of chest pain as a risk factor for myocardial infarction and to reduce the denial and delay in seeking treatment associated with the occurrence of chest pain. People experiencing even mild chest pain are encouraged to seek treatment, and friends and family members are trained to provide gentle but persistent persuasion.

Because patients who experience chest discomfort often enter the health care system through the emergency medical service (EMS) transport system, introduction of a CPER has the potential to effect EMS in several ways:

- Patients/family members may expect EMS personnel to be aware of the CPER/ECCS program and will assume EMS personnel supports it.
- The public may expect EMS personnel to be aggressive in encouraging patients with mild chest pain to seek medical treatment.
- Patients, family members, and/or bystanders may request EMS at an earlier stage in an ischemic cardiac event.
- Patients may ask to be transported to a hospital with a CPER instead of to the closest hospital.

Given the potential impact of a CPER on EMS, the present study was undertaken to determine if interaction occurred between hospitals that opened a CPER and the local EMS system.

Methods

At the time the study was initiated, 72 hospitals in the United States were reported to have opened CPERs. From this group, the 32 hospitals with CPERs served by nonhospital-based EMS systems were selected. The distinction was made on the assumption that hospital-based EMS systems would have a proprietary relationship with the emergency department, thus assuring some form of interaction. Of the 32 facilities selected, 4 had not opened CPERs as reported and 5 did not respond to the telephone survey, thus resulting in a study sample of 23 hospitals (72% response rate).

All hospital personnel who responded to the telephone survey (e.g., emergency department director, director of nursing or marketing) indicated they were knowledgeable about the interaction of their hospital with EMS. Survey questions were designed to elicit information on the working relationship between the hospital and EMS and to ascertain motivation for CPER/ECCS development. Frequency distributions and chi square or Fisher's exact tests were used to analyze responses.

Survey questions

Respondents were asked to rate their hospital's relationship with EMS according to the following suggested criteria:

- *excellent* if the hospital and EMS interact on a routine basis and develop protocols and programs jointly;
- *very good* if the hospital and EMS interact routinely with few problems;
- *good* if the hospital and EMS interact with some problems; and

- *poor* if there are numerous problems and little or no interaction.

Respondents were asked to rate the relationship between the hospital and EMS during the planning and initiation of a CPER, using the following criteria:

- *active* if the EMS system was involved at the planning stage and worked with the hospital to develop the CPER;
- *moderate* if the hospital developed the program alone, the EMS system was involved just before the CPER opened, and/or EMS served as a consultant to the hospital.
- *mild* if the hospital notified the EMS system of the opening of the CPER and other communication with the EMS system occurred as needed.
- *not at all* if the hospital opened the CPER without officially notifying EMS and there is no working relationship with EMS relative to the CPER.

Respondents also were asked:

- if the relationship with EMS changed after initiating a CPER;
- about the importance of EMS in providing functional support to the CPER (i.e., directing chest pain patients to the CPER); and
- why the hospital opened a CPER.

Results

Responses to the survey are shown in Table 1. Although the majority of respondents reported no involvement between their hospital and EMS during CPER planning and no change in the relationship between the hospital and EMS after CPER initiation, there is some evidence suggesting that the relationship does improve after joint planning ($p = 0.06$). Hospitals where EMS was considered important to the functioning of the CPER were significantly more likely to have involved EMS in the planning process ($p = 0.02$).

The reasons given for opening a CPER fell into two general groupings: public relations and/or marketing concerns; and improvement in/completion of cardiac care delivery. There was no significant association between the reason for opening a CPER and the hospital's involvement of EMS in the planning process ($p = 0.5$). There was only weak evidence of an association between respondents' perception of EMS importance and the importance of EMS to the CPER ($p = 0.1$). Thus, the reasons for opening a CPER do not seem to be associated with a hospital's involvement with EMS.

Table 1. Hospital and EMS interaction

♦ **Hospital characterization of relationship with EMS**

| | |
|-----------------|-----|
| excellent | 13% |
| very good | 61% |
| good | 26% |
| poor | 0% |

♦ **Hospital characterization of EMS involvement in CPER planning**

| | |
|--------------------|-----|
| active | 9% |
| moderate | 9% |
| mild | 17% |
| not involved | 65% |

♦ **Changes in relationship after CPER initiation**

| | |
|----------------|-----|
| improved | 30% |
| same | 70% |
| declined | 0% |

♦ **Hospital perception of EMS importance**

| | |
|---------------------|-----|
| important | 43% |
| not important | 39% |

Discussion

The relatively good relationships reported between hospitals with CPERs and the local EMS system could be due to the hospitals' not having the CPER operating long enough to develop the community outreach component completely. Thus, patients/families may not have been sufficiently aware of the CPER to result in a change in their interaction with EMS. It is also possible that some hospitals may have initiated only a CPER and not an ECCS program. In such cases, public knowledge of the CPER may be restricted to word-of-mouth or advertising by the hospital. In the Baltimore-Washington area, for example, a number of hospitals have media campaigns to promote their CPERs, but do not advertise an ECCS effort.

EMS personnel traditionally have been taught that chest pain patients are to receive advanced life support and transport to the closest hospital. If some of the surveyed hospitals were the only one in the area, they would automatically receive all chest pain patients and there would thus be no need to educate EMS personnel about the benefits of transport to a CPER. An EMS system that has a strict policy of transport to the closest hospital also may not be affected by the presence of a CPER. With such a system, however, there may be increased potential for conflict if patients demand transport to a CPER at another hospital.

While conducting the current study, the authors occasionally encountered the opinion that CPERs are "gimmicks" used by hospitals to increase revenue. It is therefore possible that some EMS providers might dismiss the role of a CPER in providing

emergency cardiac care. On the other hand, the majority of surveyed hospital personnel did not consider EMS important to the CPER, despite the fact that large numbers of patients are transported by EMS. If the CPER is a means to increase hospital revenue, it should follow that hospitals would encourage EMS to transport patients to their facilities and attempt to indoctrinate EMS about CPER benefits.

Conclusion

As the concepts of the CPER and ECCS continue to expand, their effect on EMS system utilization will warrant further study. Personnel responsible for managing EMS systems should consider taking a proactive role in working with hospitals that have CPERs, stressing the need for a community outreach component and in-service education for EMS providers. Cardiac mortality reduction cannot be accomplished without a strong, efficient EMS system. The opportunities for community interaction and support may provide many benefits to a local EMS system, especially in times of decreasing financial support.

References

1. Bahr RD. Access to early cardiac care: chest pain as a risk factor for heart attacks, and the emergence of early cardiac care centers. *Md Med J* 1992;41:133-137.
2. Hackett TP, Cassem NH. Factors contributing to delay in responding to the signs and symptoms of acute myocardial infarction. *Am J Cardiol* 1969;24:651-658.
3. Berkanovic E, Telesky C, Reeder S. Structural and social psychological factors in the decision to seek medical care for symptoms. *Medical Care* 1981;19:693-709.

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The emergency medical services board and the reorganization of the Maryland Institute for Emergency Medical Services System

Murray A. Kalish, M.D.

Dr. Kalish is chairperson of the Committee on Emergency Medical Services of the Medical and Chirurgical Faculty of Maryland.

All medical emergencies are not alike. It is vital to transport patients to the medical facility that is best equipped to meet their needs in the shortest possible time. That is why Maryland has a highly advanced, statewide emergency medical services (EMS) system that links a network of emergency communications, trained personnel, transportation, and specialized medical facilities. The Maryland Institute for Emergency Medical Services System (MIEMSS) is mandated by state law to be the lead EMS organization responsible for coordinating the statewide EMS system.

Governor William Donald Schaefer, reflecting his continued commitment to ensuring that Maryland's EMS system serves as a model for the nation, supported 1993 legislation mandating that MIEMSS report to an 11-member EMS board answering to the governor (**Table 1**). The EMS board is the first of its kind in the nation to report directly to a governor. Governor Schaefer, the EMS board and its advisory council, MIEMSS, EMS providers, and hospital personnel throughout the state stand united in their goal of working in the spirit of the new law to improve the EMS system so that it best serves all ill and injured patients in Maryland regardless of political or fiscal pressures.

The creation of the EMS board was the result of the efforts of the governor's Emergency Medical Services Commission, which met in the fall of 1992. Under the direction of Dr. James D'Orta, the commission reviewed Maryland's EMS system with the goals of improving it and preparing it for entry into the twenty-first century. The commission's work led to the introduction of House Bill 1222, which established an EMS board positioned at the executive level in the state.

Under the new legislation, the director of MIEMSS no longer serves as the director of the R Adams Cowley Shock Trauma Center.

Table 1. Maryland EMS board members

- **Chairperson
Public at Large**
Donald L. DeVries, Jr., Esq., Partner
Goodell, DeVries, Leech and Gray Attorneys at Law
- **Secretary, Maryland Department of Health and
Mental Hygiene/designee**
Nelson J. Sabatini/Tricia Slawinski
- **Representative of University of Maryland at Baltimore
(nominated by Board of Regents)**
Donald E. Wilson, M.D.
*Dean and Professor of Medicine
University of Maryland School of Medicine*
- **Emergency Medical Services Physician**
Sheila Rhodes, M.D., M.P.H., F.A.C.E.P.
*Attending Physician, Emergency Medical Services
Franklin Square and Carroll County General hospitals
Senior Physician, Baltimore Gas & Electric Company*
- **Trauma Physician**
Willie Blair, M.D., F.A.C.S.
*Associate Professor of Surgery
Prince George's County Hospital Center*
- **Emergency Medical Services Nurse**
Dennis Jones, R.N., M.S.
*Nurse Manager, Department of Emergency Medicine
Franklin Square Hospital Center*
- **Career Firefighter**
John Frazier
Staff Chief, Baltimore City Fire Department
- **Volunteer Firefighter**
Philip Hurlock
Director, Queen Anne's County Emergency Operations Center
- **Hospital Administrator**
Victor Broccolino
President, CEO, Howard County General Hospital, Inc.
- **Public at Large (county population less than 175,000)
no current appointment**
- **Chairperson of the Statewide EMS Advisory Council**
George B. Delaplaine, Jr.

How legislation affects MIEMSS

- The EMS board has the authority to make and implement decisions that affect the EMS delivery system.
- The EMS board is assisted by the Statewide EMS Advisory Council (SEMSAC), made up of representatives from organizations involved in providing emergency care services, including the director of the Shock Trauma Center and the director of the National Study Center for Trauma and EMS, which were formerly part of MIEMSS (see Table 2).

- The EMS board appoints the director of MIEMSS.
- Funding for MIEMSS comes from the State of Maryland through the EMS board.

How legislation affects Shock Trauma

- The management of the Shock Trauma Center remains with the University of Maryland Medical System (UMMS), as it has since 1984.
- The director of Shock Trauma is named by the UMMS board of directors, pending the governor's approval or a 60-day waiting period.
- The Shock Trauma director is to provide a monthly report to the UMMS board of directors and to the EMS board on the overall progress of programs.
- The Shock Trauma budget (that is, the portion funded by the EMS fund) must be approved by the UMMS board of directors, then presented to the EMS board for review and comment.
- The EMS board has the opportunity to comment before the adoption of any proposed change in Shock Trauma's budget, services, mission, or other policies that would affect the ability of the Shock Trauma Center to continue to fulfill its mission as the statewide primary adult clinical resource for emergency medical services.

How legislation affects the National Study Center

- The director of the National Study Center is appointed by the University of Maryland at Baltimore (UMAB) president, pending the governor's approval or a 60-day waiting period.
- The director of the center works with the MIEMSS executive director in developing a research plan and budget.

Duties of EMS board

The EMS board has numerous duties, including the review and approval of the EMS operations fund budgets of MIEMSS, the Shock Trauma Center, the Maryland Fire and Rescue Institute, and the Med-Evac portion of the Aviation Division of the Maryland State Police. Other board duties include

- study and analysis of EMS;
- review and approval of the state's EMS budget;
- application for funds;
- publication of information related to EMS service delivery;
- appointment of the executive director of MIEMSS;

Table 2. Statewide EMS Advisory Council

As specified in the legislation creating the Statewide Emergency Medical Services Advisory Council (SEMSAC), the following organizations submitted the names of three qualified nominees to the EMS board, which then selected the following representatives to serve on the council and submitted the list to the governor, who approved them. The SEMSAC members represent various types of EMS providers and consumers.

- | | |
|--|--|
| ○ Richey D. Adams, EMT-A Medical Technician, Bethesda-Chevy Chase Rescue Squad | ○ Leon Hayes Region V, EMS Advisory Council |
| ○ John W. Ashworth, III Director, R Adams Cowley Shock Trauma Center | ○ Major Johnny L. Hughes Commander, Aviation Division, Maryland State Police |
| ○ Allan E. Atzrott President, Prince George's Hospital Center | ○ Murray A. Kalish, M.D. Chairperson, Committee on Emergency Medical Services Medical and Chirurgical Faculty of Maryland |
| ○ Robert A. Barish, M.D. Director, Emergency Medical Services University of Maryland Medical Center | ○ Bernard Koman Maryland Commercial Ambulance Service |
| ○ Julie Ann P. Casani, M.D., M.P.H. Regional Medical Director, EMS Region III | ○ Ronald Lipps Chief, Traffic Safety Division, State Highway Administration |
| ○ Victoria J. Coombs, R.N. President, Chesapeake Bay Chapter, American Association of Emergency Critical Care Nurses | ○ Frederick W. Miltenberger, M.D. Region I, EMS Advisory Council |
| ○ Mary S. Coburn, R.N. Maryland State Council of the Emergency Nurses Association | ○ The Honorable Ethel A. Murray Maryland House of Delegates (Cecil County) |
| ○ Brad M. Cushing, M.D. Director, National Study Center for Trauma and Emergency Medical Systems | ○ Charles W. Riley Chairperson, Legislative Committee, Maryland State Firemen's Association |
| ○ Chairperson George G. Delaplaine, Jr. Region II, EMS Advisory Council | ○ R. Chris Shimer Lieutenant, Howard County Fire and Rescue Services |
| ○ Dorothy Dyott, R.N. Region IV, EMS Advisory Council | ○ Roger Simonds Region III, EMS Advisory Council Deputy Chief, Emergency Medical Services and Special Operations, Anne Arundel County Fire Department |
| ○ Steven T. Edwards Director, University of Maryland Fire and Rescue Institute | ○ James Andrew Sumner, M.D. Board of Physician Quality Assurance |
| ○ Rhonda S. Fishel, M.D. Assistant Surgeon-in-Chief, Critical Care Medicine Sinai Hospital of Baltimore | ○ Lynn Workmeister General Public (county less than 175,000) Allegany County |

- preparation and submission of an annual report to the governor and general assembly on patients transported to all trauma centers in the state;
- preparation of and ensurance of compliance with the EMS plan; and
- adoption of regulations to implement the EMS plan.

Although the EMS board has rule-making authority, it uses consensus building as a means to enhance cooperative excellence.

Duties of SEMSAC

The EMS board is assisted by the MIEMSS staff and the

Statewide EMS Advisory Council. The latter, representing statewide EMS interests, serves as the board's principal advisory body and ensures that regional issues are effectively represented at the state level. The board looks to SEMSAC for support, direction, advice, and input.

In the legislation that created the EMS board and SEMSAC, the 1993 Maryland General Assembly charged SEMSAC with the following responsibilities (in addition to its advisory role to the EMS board):

- to "provide a means by which regional emergency medical services interests can be represented at a statewide level";

- to “assist in the development of goals for and facilitate the implementation of a comprehensive emergency medical services plan”; and
- to “provide assistance in the resolution of interregional and interstate emergency medical services system problems and concerns.”

EMS plan to be developed

The EMS board must develop and adopt an EMS plan to ensure effective coordination and evaluation of services in Maryland. The plan shall include

- criteria for designation of trauma and specialty referral facilities;
- a plan to maintain and enhance the communications and transportation system;
- provisions for the evaluation of EMS personnel training programs;
- criteria to evaluate the system’s effectiveness; and
- provisions for the establishment of a public information and education program.

The planning process is key to the future direction of EMS in Maryland. The plan will serve as the centerpiece from which all branches of the system develop. The EMS board is committed to securing input from all regions of Maryland and all participants in the system. The board’s planning committee is working through the five Maryland EMS regions to ensure this participation. The board shall also adopt regulations to implement the plan.

Working with the executive director of MIEMSS, the board also must

- coordinate the EMS system statewide, including the five EMS regions;
- coordinate training and certification, research and education, and communications for EMS;
- coordinate the development of centers that treat emergency injuries and the development of specialty referral centers; and
- ensure continued improvement of transportation for emergency, critically ill, and critically injured patients.

During the past year, the EMS board actively participated in and advocated for EMS in legislative matters. The board was a motivating force in the plan implemented to enhance Med-Evac coverage in southern Maryland and on the Eastern Shore and effectively worked to ensure that interest accrued by the EMS Fund would be maintained in the fund for EMS purposes.

Maryland’s Five EMS Regions

Region I

..... Garrett and Allegany counties

Region II

..... Washington and Frederick counties

Region III

..... Baltimore City and Carroll, Howard, Anne Arundel, Baltimore, and Harford counties

Region IV

..... Cecil, Kent, Queen Anne’s, Talbot, Caroline, Dorchester, Wicomico, Somerset, and Worcester counties

Region V

..... Montgomery, Prince George’s, Charles, Calvert, and St. Mary’s counties

EMS in the future

Maryland has been at the forefront of health care and a leader in the delivery of emergency medical services. Since the early 1970s, Maryland has served as a model for coordinated EMS. The marriage of the goals and activities of the prehospital and hospital providers into a unified state program initially set Maryland apart from other programs.

The tenacity of R Adams Cowley, M.D., founder of MIEMSS, and the vision and cooperation of Governor Schaefer helped Maryland establish itself as the premier EMS system. Annual infusions of special “enhancement funds” by the legislature have been key to the upgrading of the communications and training programs in Maryland. The commitment of the state to a modern fleet of helicopters and Med-Evac transports was key to maintaining our place in EMS. The efforts of Governor Schaefer, along with EMS provider support, ensured stable future funding for EMS when the 1992 legislature established an EMS operations fund through an eight-dollar increase in vehicle registration fees.

Maryland has a sound EMS system from which to move forward into the twenty-first century. But we must not be comfortable with what is. We must be determined to reach what we can be.

Acknowledgement

The author wishes to thank MIEMSS personnel for their kind assistance in providing information for this article. ■

The Maryland State Police Aviation Division Emergency Medicine Protocol

Ruth M. Seaby, M.A.S.

Ms. Seaby is the director of communications of the Medical and Chirurgical Faculty of Maryland.

In 1968, with funding from a grant from the U.S. Department of Transportation, the Maryland State Police Aviation Division and the University of Maryland Medical Center established the first aerial medical evacuation program in the country. Although the aviation division transported less than 100 patients during its first year in operation, that number has grown steadily. To date, more than 50,000 patients have used the Med-Evac system.¹ In fiscal year 1994, 4,092 patients were transported—3,448 from the scene of an injury and 664 from one hospital to another (Table 1).²

Practicing on sophisticated mannequins, Maryland State Police flight paramedics receive extensive training, both in the classroom and in complex trauma simulation exercises. They were the first prehospital providers in Maryland to use mechanical ventilators, to place an intraosseous needle, to perform a pleural decompression, and to perform a nasotracheal intubation.¹ Intubation is an especially valuable procedure in unconscious patients with severe head injuries, and pleural decompression has been instrumental in saving the lives of some patients with severe chest trauma.² Following is the protocol used by the Maryland State Police Aviation Division for medical transports.³

Protocol

Maryland has been one of the national leaders in the development of emergency medical services systems (EMS). The EMS system provides care for emergency patients dependent upon a rapid evaluation and transport from the scene of the incident to appropriate medical facilities. The Maryland EMS system has developed and designated specialty referral centers and a series of trauma centers throughout the state to provide an appropriate level of care. The Maryland EMS system is supported by the Maryland State Police Aviation Division helicopters.

Table 1. Maryland State Police medical emergency helicopter transports during fiscal year 1994

Trauma

| | |
|--------------------------------------|------|
| ▼ automobile injuries | 2056 |
| ▼ falls, recreational injuries | 668 |
| ▼ pediatric injuries | 457 |
| ▼ assaults | 155 |
| ▼ shootings | 150 |
| ▼ burns | 116 |
| ▼ hand injuries | 84 |
| ▼ eye injuries | 18 |

Medical

| | |
|---|-----|
| ▼ neonatal | 140 |
| ▼ stroke | 39 |
| ▼ cardiac | 33 |
| ▼ respiratory distress | 30 |
| ▼ seizures | 25 |
| ▼ obstetrical | 17 |
| ▼ poisoning | 11 |
| ▼ overdose | 7 |
| ▼ other (aneurysm, GI bleeding, sepsis, etc.) | 86 |

Staffing

Medical care of patients on board agency aircraft will be provided primarily by the aviation division EMT paramedics.

Occasionally, medical support personnel are necessary to assist the paramedic with the management of a patient, or during double patient transfers. Although additional personnel are used for assistance, the division paramedic will be responsible for all medical care administered to each patient.

Certain transports require specialized care or technical support which will be provided by an additional health care provider (i.e., physician, neonatal nurse, etc.).

In all cases, however, whenever a patient is on board the aircraft, the division paramedic will physically be in the helicopter service area.

Medical transports

Types of medical missions. Agency helicopters are available to transport persons with serious traumatic injuries or life-threatening illness to an EMS designated treatment center or referral center. These patients may be flown directly from the scene of an incident or from a health care facility.

Serum/organ transports may be made when the patient's life is in immediate jeopardy or viability of the serum/organ will be compromised by long land transport.

Transportation of medicine or medical supplies, or the medical evacuation of ill/injured persons may be necessary during disasters or when genuinely not accessible by ground units.

Specialty referral centers. Generally, all patients will be transported to facilities affiliated within the MIEMSS [Maryland Institute for Emergency Medical Services Systems]. Specialty referral centers are as follows:

• **Adult trauma**

- R Adams Cowley Shock Trauma Center, Baltimore City, Maryland
- Francis Scott Key Medical Center, Baltimore City, Maryland
- Johns Hopkins Hospital, Baltimore City, Maryland
- Memorial Hospital, Cumberland, Maryland
- Peninsula General Hospital, Salisbury, Maryland
- Sinai Hospital, Baltimore City, Maryland
- Suburban Hospital, Bethesda, Maryland
- Washington Hospital Center, Medstar, Washington, DC
- Prince George's General Hospital, Cheverly, Maryland
- Washington County Hospital, Hagerstown, Maryland

• **Eye trauma**

- Wilmer Eye Clinic, Johns Hopkins Hospital, Baltimore City, Maryland
- Center for Sight, Georgetown University, Washington, DC

• **Hand/extremity trauma**

- Curtis Hand Center, Union Memorial Hospital, Baltimore City, Maryland

• **Hyperbaric medicine/therapy**

- R Adams Cowley Shock Trauma Center, Baltimore City, Maryland

• **Pediatric trauma**

- Johns Hopkins Hospital, Baltimore City, Maryland
- Children's Hospital Center, Washington, DC

• **Neonatal**

- Francis Scott Key Medical Center, Baltimore City, Maryland
- Greater Baltimore Medical Center, Baltimore County, Maryland

- Johns Hopkins Hospital, Baltimore City, Maryland
- University of Maryland Hospital, Baltimore City, Maryland
- Mercy Hospital, Baltimore City, Maryland
- St. Agnes Hospital, Baltimore City, Maryland
- Sinai Hospital, Baltimore City, Maryland

● **High-risk maternal**

- Johns Hopkins Hospital, Baltimore City, Maryland
- University of Maryland, Baltimore City, Maryland
- Francis Scott Key Medical Center, Baltimore City, Maryland

● **Burns**

- Baltimore Regional Burn Center, Francis Scott Key Medical Center, Baltimore City, Maryland
- Washington Burn Center, Washington Hospital Center, Washington, DC

● **Spinal cord**

- R Adams Cowley Shock Trauma Center, Baltimore City, Maryland

Exceptions

Patients may be diverted to other facilities (i.e., regional trauma centers or local hospitals) under the discretion of the Med-Evac crew due to severe weather conditions, extreme instability of patient including unmanageability, mechanical failure of aircraft, or receiving hospital on fly-by status.

Occasionally, a patient suffering a particular illness or injury may be flown into a hospital that is not a part of MIEMMS. This will be a rarity and must first be approved by the officer of the day *and* by the aeromedical director or designee.

References

1. Gabriele MB. Aviation division approaches 25th anniversary. *The Trooper* Summer 1994:54–55.
2. Maryland State Police Aviation Division. Annual Report to the Superintendent. 1994
3. Maryland State Police Aviation Division Manual, pp. 5–1 to 5–5. ■

**Maryland State Police Aviation
Division Operations Bases**

| | |
|------------------|--|
| <i>Trooper 1</i> | Martin State Airport, Baltimore County |
| <i>Trooper 2</i> | Andrews Air Force Base, Prince George's County |
| <i>Trooper 3</i> | Frederick Municipal Airport, Frederick County |
| <i>Trooper 4</i> | Wicomico County Airport |
| <i>Trooper 5</i> | Cumberland, Allegany County |
| <i>Trooper 6</i> | Centreville, Queen Anne's County |
| <i>Trooper 7</i> | St. Mary's County Airport |
| <i>Trooper 8</i> | Norwood, Montgomery County |

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The Shock Trauma Center at the University of Maryland Medical Center: an interview with John Ashworth

Vivian Smith

Ms. Smith is assistant director of communications of the Medical and Chirurgical Faculty of Maryland

One cannot talk about the past, present, or future of the Shock Trauma Center without acknowledging R Adams Cowley, M.D., the man who created the center and whose vision grew into the Maryland Institute for Emergency Medical Services System (MIEMSS), which once included the statewide emergency medical services (EMS) system as well as the Shock Trauma Center. Asked in a 1978 interview for the *Maryland State Medical Journal* where the state EMS program was going, Dr. Cowley replied that the focus had always been on delivering better quality and more complex care. But, he indicated, a second focus had recently been introduced—“cost effectiveness.”¹

Sixteen years later, John W. Ashworth, III, MHA, University of Maryland Medical System (UMMS) senior vice president of strategic planning, program development, and communications and Shock Trauma Center director, acknowledges that transporting injured people to high quality care at an appropriate site is of foremost importance. However, he also recognizes that the health system reform imperative that is coming from society intensifies the need to manage utilization. For Shock Trauma, he says, that means “appropriately managing our costs simultaneously with enhancing quality.”

It has been more than a year since the implementation of House Bill 1222 changed the long-standing reporting relationships between the Shock Trauma Center and MIEMSS, the lead EMS organization responsible for coordinating Maryland’s statewide EMS system (see article on page 1057). During that year, Mr. Ashworth says, “we’ve really been taking a good look at ourselves and asking, how do we as an organization of shock trauma, given our extraordinary resources, keep ourselves on the top in achieving extraordinary results?”

SEMSAC

In the past year, while MIEMSS was searching for its new executive director, Donald L. DeVries, Jr., Esq., chairman of the EMS board, began

John Ashworth entered the health care field in September 1971, when he became the administrator for the shock trauma unit, a highly advanced 12-bed unit of the University of Maryland Hospital. In 1973, he became the administrator of MIEMSS, which at the time was Shock Trauma, the major adult trauma hospital in Maryland. In 1977, as director of administration and finance of MIEMSS, Mr. Ashworth assumed responsibility for the overall operations of the state's EMS system. By 1980, Shock Trauma had grown to a 72-bed unit, and Mr. Ashworth became the executive director of MIEMSS, encompassing the state's EMS system and the Shock Trauma Center. Continued growth of the center led to the need for new accommodations; in 1989 the Shock Trauma Center moved into its current facility adjacent to the University of Maryland Hospital. It is now a licensed 138-bed facility that admitted 5,300 trauma victims last year. It has legally been part of the University of Maryland Medical Center since 1984.

One question that typically arises in physician circles is why the director of the Shock Trauma Center is not required to have a medical degree. Mr. Ashworth replies that it is important to understand that although he is responsible for directing the activities of the center, there are many physicians who play a key role in the clinical aspects of the center, including Howard S. Eisenberg, M.D., the medical director of shock trauma and head of the UMMS neurosurgery department. Mr. Ashworth stresses, the "key is getting the right person for the job." He says leadership means setting direction, allotting constituencies, and motivating and inspiring, while management is planning, organizing, staffing, directing, and controlling. You must ask, he continues, what kind of individual fits those criteria? "If it is a physician who can fit that criteria, then that's good; if it is a nonphysician who can fit that criteria, then that's good."

assembling the State Emergency Medical Services Advisory Council (SEMSAC) and drafting the state EMS plan. According to Mr. Ashworth, this has been a bottom-up process, based on the grassroots understanding of EMS issues. A ten-member subcommittee of SEMSAC, which Mr. Ashworth chairs, was formed to act as the core planning group. The subcommittee's recommended goals and objectives will be reviewed by SEMSAC and recommendations will be forwarded to MIEMSS and the EMS community for comment. Mr. Ashworth predicts that Maryland will have a state EMS plan in about six months, which he says will be a great achievement for Mr. DeVries. "The Shock Trauma Center," says Mr. Ashworth, "will not exist unless the EMS providers, and all the other stakeholders, sense the value here."

Discussing the hiring of Robert Bass, M.D., the new executive director of MIEMSS, Mr. Ashworth said the timing was good, because Dr. Bass will be largely responsible for imple-

menting the evolving state EMS plan. Mr. Ashworth is confident that he, Mr. DeVries, and Dr. Bass will develop a synergistic relationship.

Relationship of Maryland trauma centers

MIEMSS coordinates the delivery of trauma services throughout the state by designating trauma centers based on type and place of injury (see article on p. 1057). While the Shock Trauma Center remains the "core element of the state EMS system," other centers are designated by MIEMSS to handle certain types of trauma. Shock Trauma has a statewide role for patients with the most severe injuries, multiple trauma, and spinal injuries. Mr. Ashworth explains that Shock Trauma was included in the legislation of the EMS system because it is so critical to the system. Any issues that might change Shock Trauma's nature could have a ripple effect on the EMS provider system. "Shock Trauma is not just another trauma center. It is the clinical resource center for the state EMS system, a place of learning, as well as a place of care. And it is a resource for prehospital care providers. It is a facility totally dedicated to trauma care."

Effectiveness of shock trauma centers

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) is compiling a patient outcomes or clinical indicator database in relation to delivery of trauma care. Mr. Ashworth believes this will provide an excellent database for the Shock Trauma Center because it will be able to demonstrate whether a patient delivered to a trauma center receives better care than a patient delivered to a hospital that does not have a trauma response mechanism. Referring to the

health system reform environment, in which the purchaser of care will be focused on value, price, and outcome, Mr. Ashworth says it will be essential to show, with well-founded data, that trauma patients treated in trauma centers have significantly better outcomes than trauma patients treated at a nontrauma center.

Data from the Shock Trauma Center show that, within the center, mortality, adjusted for severity of injury, is declining. Mr. Ashworth says there are many reasons for the decline, including the likelihood of patients being stable at admission because of the caliber of prehospital care. He believes that morbidity assessment, within Shock Trauma specifically and in trauma care generically, requires more research. "To more fully describe the strengths of an EMS system or a trauma center, we must study our patients' functional status five, eight, and ten years after their injury and after they resume their pre-injury activities."

A major area of investigation has been the development of good outcome indicators that are temporally related to the delivery of health care, including the obvious outcome measure of life or death. But the quality of life after care involves looking at what makes a difference in terms of what is or is not done. Mr. Ashworth believes Shock Trauma is effective in utilization management because it is based on delivering the high quality service, the critical care, and the resources available can be modified so as not to affect outcomes. Mr. Ashworth stresses that "trauma care is not immune to managed care concepts; it is not isolated from the competitive forces of the marketplace."

The trauma center is also participating in the Major Trauma Outcome Study (MTOS), a comparative analysis that evaluates the performance of individual trauma centers and provides the foundation for national standards for trauma care. The MTOS analyzes demographic, etiologic, injury severity, and outcome data in relation to predictable and unexpected mortality rates. Although national statistics are important to evaluating the effectiveness of trauma centers, Mr. Ashworth points out that such information must be used appropriately. Nevertheless, he believes that when national information is compiled, "the public will find great comfort in knowing how good the care rendered in the Shock Trauma Center is."

Rehabilitation

Shock Trauma has developed a continuum of care. Many patients are moved into comprehensive inpatient rehabilitation or entered into the second largest home health care program in the state, which has helped move trauma patients rapidly through the system into high quality, lower cost alternatives. The University of Maryland Medical System has created a rehabilitation network of which Montebello Rehabilitation Hospital is the cornerstone. Montebello is in the process of merging its resources with the rehabilitation services of The James Lawrence Kernan Hospital to become the William Donald Schaefer Rehabilitation Center at Kernan, which will be the largest rehabilitation facility in the state for comprehensive inpatient care. With a segmented system, explains Mr. Ashworth, there are costs at every phase of care, and the cumulative cost of each phase is going to be much higher than an integrated trauma care system. He believes the overall costs are reduced dramatically by shortening the length of stay in Shock Trauma and by guaranteeing continuing quality care in the restorative phases of recovery from traumatic injury.

Prevention

Statistics show that across the country, drug- and alcohol-related vehicular accidents are responsible for 50% of trauma injuries. According to Mr. Ashworth, Shock Trauma Center data reflect this national trend in terms of the number of patients,

but the types of injuries sustained in crashes are changing. Airbags, for example, are creating different kinds of orthopedic injuries: more people are surviving crashes and being admitted with complex lower extremity and pelvic injuries. In addition, an increased number of patients are coming into the EMS system as a result of societal and family violence. "People are finding different ways to hurt each other," says Mr. Ashworth. "We see many baseball bat injuries; baseball bats have become very popular as weapons."

Believing that prevention is critical, Mr. Ashworth feels that trauma centers have a role in working with the community. He says trauma centers also need to educate primary care practitioners, who in turn can help educate their communities to stop behavior patterns that result in admission to a trauma center. Shock Trauma has helped in research related to automobile safety, opposed anti-helmet and anti-seatbelt advocates in Annapolis, and supported the federal program to ban assault weapons. Last spring, the Shock Trauma Center began a pilot study of violence prevention that involves profiling characteristics (e.g., marital conflict, unemployment, drug and alcohol problems) that may lead to trauma center admission. Because there is a high rate of recidivism for many victims of violence, the study deals with the above-mentioned characteristics through the University of Maryland School of Social Work and job placement services, and then works with the individuals to not only heal physical wounds, but to place them as spokespersons on violence avoidance in their communities.

New curriculum at the University of Maryland School of Medicine

In September, the executive committee of the University of Maryland School of Medicine approved the establishment of a trauma curriculum that Mr. Ashworth says will be focused on research and education initiatives, as well as the clinical initiatives of the Shock Trauma Center. The program is very rare and Mr. Ashworth acknowledges the tremendous support the dean, Donald E. Wilson, M.D., gave the development of the trauma program. According to Mr. Ashworth, his long-range plan includes the pursuit of high quality initiatives, the evolution of the trauma program to meet today's societal needs, and the positioning of the Shock Trauma Center to do well in the constantly changing health care environment.

Reference

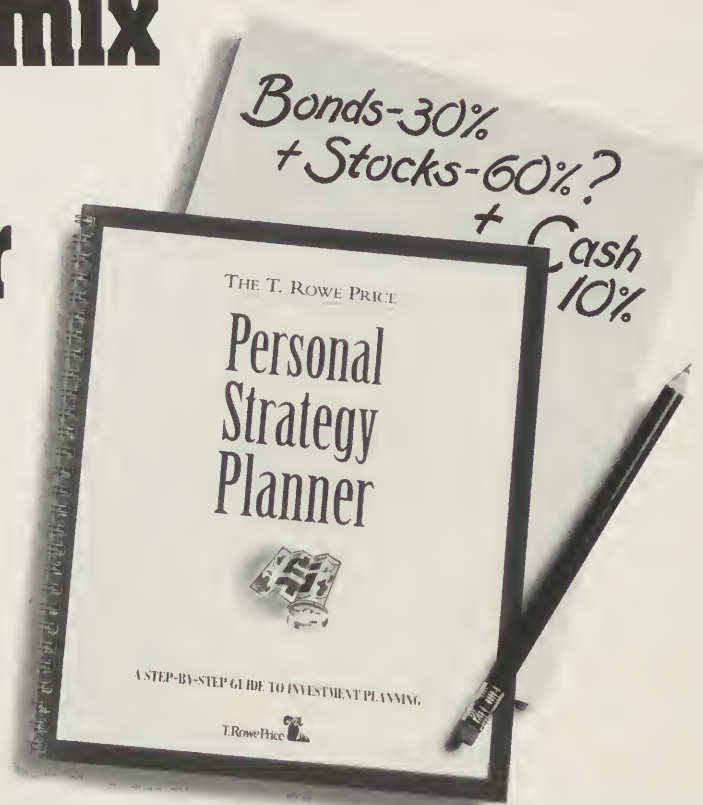
1. Taylor B. Close encounters of the Cowley kind: an exclusive Journal interview with R Adams Cowley, MD, director of the Maryland Institute for Emergency Medical Services, State of Maryland. *MD State Med J* 1978;27(6):35-49. ■

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Pertinent medical intelligence: the poppy seed

Joseph M. Miller, M.D.

*Dr. Miller is a retired surgeon from
Timonium, Maryland.*

The fact that poppy seeds, commonly used in bakery products, may occasion a positive opiate test in the urine is generally unappreciated. Recent investigations, however, have defined the problem and offered tangible solutions to its recognition.

The poppy, existing in more than 100 species, is a beautiful annual, biennial, or perennial plant. Natives of Europe, eastern Asia, and North America, they belong to the family Papaveraceae. Best known to medicine and the forensic sciences is the Oriental poppy (*P. somniferum*), which is a perennial, two to three feet high, with immense cup-shaped flowers. The milky juice obtained from its unripe seed capsule is the source of crude opium and its alkaloids, only a few of which (morphine, codeine, and papaverine) are clinically useful.

The seeds have been thought to be free of opiates,^{1,2} but recent investigations have changed this view. In addition to demonstrating their presence in poppy seeds, Struempler³⁻⁵ was instrumental in having the detection level of codeine or morphine raised from 300 ng/ml to 2000 ng/ml for codeine and 4000 ng/ml for morphine. The higher concentration precludes the possibility of a false positive report from poppy seed ingestion.

ElSohly and Jones,⁶ reviewing their own results and those of a number of other investigators, showed clearly and conclusively that small amounts of morphine and codeine (usually less than 200 µg of morphine per gram of seeds and much less codeine) are present. Quantities are sufficient, however, to produce positive urine tests. Individuals who ingest products containing poppy seeds usually will exhibit a positive examination in four hours.

Mule and Casella,⁷ aware of this possibility, have suggested that a resolution of the problem in such cases may be accomplished by examining the urine for 6-monoacetylmorphine. If this metabolite is present, the person tested is a "user," because eating poppy seed products will not produce this substance.

People being considered for sensitive business positions or those connected with the Department of Defense may be required to submit to a urine

opiate test. If they have ingested bakery products containing poppy seeds within one day of the test, a positive finding for morphine (greater than 300 ng/ml) may be encountered. Extreme caution, however, must be exercised in the interpretation of such tests.

References

1. Dobelis IN, ed. *Opium Poppy. Magic and Medicine in Plants*. Pleasantville, NY: The Reader's Digest Association; 1986:381-382.
2. Considine DM, ed. *Van Nostrand's Scientific Encyclopedia*. 6th ed. New York: Van Nostrand Reinhold Company; 1983:2291.
3. Struempier RE. Excretion of codeine and morphine following ingestion of poppy seed rolls. *J Anal Toxicol* 1987;11:97-99.
4. Struempier RE. Excretion of morphine in urine following the ingestion of poppy seeds. *Mil Med* 1988;153:468-470.
5. Struempier RE. Letter to the editor. *Mil Med* 1990;155:A8.
6. ElSohly MA, Jones AB. Morphine and codeine in biological fluids: approaches to source differentiation. *Forensic Science Review* 1989;1:14-19.
7. Mule SJ, Casella GA. Rendering the "poppy-seed defense" defenseless: identification of 6-monoacetylmorphine in urine by gas chromatography/mass spectroscopy. *Clin Chem* 1988;34:1427-1430. ■

Less than two weeks after Dr. Miller submitted his poppy seed article to MMJ, Dan Rodricks,¹ a columnist for The Sun, described a case in which a nurse practitioner with a fondness for poppy seed bagels was denied employment at a Baltimore community health center because her urine tested positive for morphine. According to Mr. Rodricks' report, the woman had eaten poppy seeds within 24 hours of the drug test. Although a subsequent physical examination showed no evidence that she used drugs intravenously, the examining physician dismissed the idea that poppy seeds could account for a positive result on a urinalysis. The nurse practitioner, refused an opportunity for a second urinalysis, was disqualified for consideration for employment by the health center.

Reference

1. Rodricks D. For the love of a poppy seed bagel, she may have lost a job. *The Sun*, October 19, 1994.

1954:

- *Dienbienphu falls to Vietnamese communists*
- *The first Newport Jazz Festival is held*
- *Five congressmen, including George Fallon of Maryland, are shot on the floor of the U.S. House of Representatives*
- *Enders shares the Nobel Prize for medicine*
- *Salk begins polio vaccinations in Pittsburgh*

Acute Poliomyelitis in Maryland. Clinical Management

Excerpted from the *Maryland State Medical Journal* 1954; 3(3): 108–112.

Martin A. Hoffman, M.D., and Laurence Finberg, M.D.

Dr. Hoffman was a resident in pediatrics and Dr. Finberg was assistant chief of pediatrics at Baltimore City Hospitals. Dr. Finberg also was an instructor in pediatrics at The Johns Hopkins University School of Medicine.

Since the winter of 1949 the contagious disease center for most of Maryland has been Baltimore City Hospitals. . . . During annual outbreaks of poliomyelitis the institution serves a dual role: first, to provide hospitalization for patients in the acute phase of the illness and such early convalescent care as may be indicated; secondly, to function as a diagnostic center to which physicians in Baltimore and in the various counties . . . may refer patients. . . .

Since 1950 there have been 761 patients with poliomyelitis admitted. This accounts for a large proportion of the patients with poliomyelitis hospitalized in both Baltimore and Maryland. Statistics for 1953 from the Baltimore City Health Department and the State Health Department reveal that hospitals within the city of Baltimore (excluding Baltimore City Hospitals) admitted 17 patients with poliomyelitis and hospitals in the various counties admitted 20 such patients (this excludes Montgomery and Prince Georges counties, who had 44 and 33 patients, respectively, admitted either to local hospitals or to hospitals in Washington, D.C.).

During each poliomyelitis season the facilities of Baltimore City Hospitals are utilized for the referral of suspected cases of poliomyelitis. By performing diagnostic lumbar punctures, and such hematological and radiological studies as seem indicated, efforts are made to provide a diagnosis. . . .

A Look Back

Emphasis is placed on admitting to the hospital all poliomyelitis patients in the acute phase of their illness who have definite or suspected bulbar involvement. These patients may present with difficulty swallowing, nasal voice, facial nerve weakness, accumulation of pharyngeal secretions or ophthalmoplegia. Weakness of muscles innervated by the upper cervical cord or the presence of encephalitic manifestations are ominous additional warning signs.

Confirmation of the referring diagnosis has been made in approximately two thirds of those patients sent in as having poliomyelitis. Among the remainder a variety of other illnesses was diagnosed. . . . These illnesses included: acute bacterial and tuberculous meningitis, polyneuritis, meningismus accompanying pneumonia, rheumatic fever, acute osteomyelitis, lead poisoning, viral encephalitis (especially mumps), fractures, soft tissue trauma, and hysteria.

Weekly admission rates

Figure 1 presents a comparison of weekly admission rates of poliomyelitis patients to Baltimore City Hospitals in each of the three peak years 1950, 1952, and 1953.

Geographical distribution of patients

Table I presents the number of poliomyelitis patients admitted annually from 1950 through 1953 to the medical and pediatric services from the city of Baltimore and from various counties within the state. In the four year period 53% of those admitted were residents of Baltimore, 27% of Baltimore County, and the remaining 18% of 18 other counties.

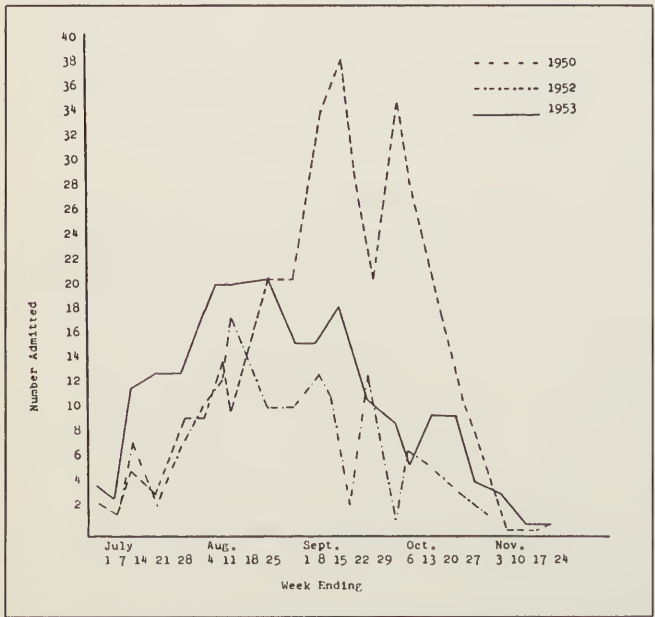


Figure 1. Weekly admissions of poliomyelitis patients—1950, 1952, 1953

Table I. Geographical Distribution of Patients

| AREA | 1950 | | 1951 | | 1952 | | 1953 | | TOTAL |
|-----------------------|------|-----|------|----|------|-----|------|-----|-------|
| | M | P | M | P | M | P | M | P | |
| Baltimore City . . . | 47 | 168 | 4 | 12 | 12 | 45 | 28 | 86 | 402 |
| Counties of Maryland: | | | | | | | | | |
| Allegany | 1 | | | | | | | | 1 |
| Anne Arundel . . . | 2 | 9 | 1 | | | 4 | 1 | 15 | 32 |
| Baltimore | 22 | 60 | 3 | 4 | 6 | 36 | 30 | 59 | 220 |
| Calvert | | | | | | | | 1 | 1 |
| Caroline | | | | | | | | 1 | 1 |
| Carroll | | 6 | | | 1 | 1 | 2 | 2 | 12 |
| Cecil | | 1 | | | | 1 | | 1 | 3 |
| Charles | | | | 2 | | | | 2 | 4 |
| Frederick | 2 | 3 | | | 3 | 10 | 2 | 3 | 23 |
| Harford | | 7 | | 1 | 1 | 6 | | 3 | 18 |
| Howard | 2 | 1 | | | 1 | | 3 | 5 | 12 |
| Pr. George | | 1 | | | | | | | 1 |
| Queen Anne | | | | | | 1 | | 5 | 6 |
| St. Mary's | 2 | 1 | | | | 1 | | 2 | 6 |
| Somerset | | 2 | | | | | | | 2 |
| Talbot | | | | | | | | 2 | 2 |
| Washington | | | | | 1 | | 1 | 1 | 3 |
| Wicomico | | 4 | | | | | | | 4 |
| Worcester | | 1 | | | 1 | 6 | | | 8 |
| Total | 78 | 264 | 8 | 19 | 26 | 111 | 67 | 188 | 761 |

M—Medical service, over 15 years of age.
P—Pediatric service, under 15 years of age.

Clinical classification of patients admitted

The various categories of poliomyelitis patients admitted to each service in the four year period is illustrated in Table II. The diagnosis of non-paralytic poliomyelitis is (except where virological laboratory facilities are available) a presumptive one. . . .

Age distribution

Table III shows the age distribution of patients who were hospitalized in 1950 and 1953. Similar distributions prevailed in the other years that were studied. In the four year period ages ranged from four months to 65 years.

Management of milder forms of the disease

In those patients whose life is not threatened by bulbar or respiratory muscle paralysis, the management is directed toward relief of symptoms, accurate periodic re-appraisal of the extent of involvement, control of metabolic derangements, and support of the morale.

Urinary retention is not uncommon in lower spinal involvement. In children the parasympatheticomimetic drug, furmethide®, was found useful in doses of one to six mgm.

Table II. Clinical Classification of Patients

| | NON-PARALYTIC | | SPINAL PARALYTIC | | BULBAR | | TOTAL |
|-----------|---------------|----------|------------------|----------|--------|----------|-------|
| | No. | Per cent | No. | Per cent | No. | Per cent | |
| 1950 | 92 | 27 | 201 | 59 | 49 | 14 | 342 |
| 1951 | 10 | 37 | 14 | 52 | 3 | 11 | 27 |
| 1952 | 36 | 26 | 77 | 56 | 24 | 18 | 137 |
| 1953 | 76 | 30 | 120 | 47 | 59 | 23 | 255 |
| Total.... | 214 | 28 | 412 | 54 | 135 | 18 | 761 |

Table III. Age Distribution of Patients in 1950 and 1953

| | 1950 | | 1953 | |
|-----------------|------|------------|------|------------|
| | No. | % of total | No. | % of total |
| Under 1 yr..... | 12 | 3.5 | 6 | 2.4 |
| 1-4..... | 83 | 24.2 | 74 | 29.1 |
| 5-9..... | 120 | 35.1 | 75 | 29.4 |
| 10-14..... | 49 | 14.4 | 33 | 12.8 |
| Over 15..... | 78 | 22.8 | 67 | 26.3 |

Occasionally catheterization was necessary, particularly in older patients. Constipation was frequently encountered and treated with enemas. Painful muscles from hyperextension and "spasm" were aided in some instances by moist heat applications, at times with analgesics, and occasionally with splints. Patients with mild pharyngeal muscle paralysis were adequately managed by mechanical suctioning of oropharyngeal secretion plus proper guidance of oral intake. . . .

In patients in whom there was extensive paralysis of three or four extremities, attention was given to the problem of calcium balance. At present such studies remain in the field of clinical and biochemical investigation, but hypercalcuria and early osteoporosis can be detected during the subacute stages of the illness.

Psychological factors appear of great importance in the moderately ill patients with poliomyelitis. Limited personnel, under the conditions of a large outbreak, restrict the scope of aid that can be accomplished. Volunteer groups were helpful in this respect at times.

Management of severe forms of the disease

The patients with extensive bulbar involvement . . . are the most severely ill. Either a tracheotomy, a mechanical respirator, or both is generally needed in their management. In

1953 there were a total of 23 tracheotomies performed, 17 in adults and 6 in children. . . . Antibiotics were used in the prophylaxis of pneumonia, tracheitis, and mediastinitis. Effort was also made, at least initially, to provide an atmosphere of high humidity to minimize the occurrence of viscid secretions.

In 1953 twelve pediatric and sixteen adult patients were placed in tank respirators. Nurses were constantly in attendance to ensure the continuous operation of the respirators under specified conditions and to help prevent such complications as hypostatic pneumonia and decubitus ulcers. All the adults placed in respirators received a tracheotomy to facilitate their subsequent nursing care. Many respirator patients were initially maintained on parenteral fluids and attention was directed at maintaining their electrolyte balance and assessing the respiratory acidosis and alkalosis so frequently occurring in such patients. Aspiration pneumonia is a common and often troublesome complication. In fulminant cases it may appear very early and play an important role in the mortality.

Mortality

In **Table IV** are given the deaths and case fatalities occurring in each year at different age ranges. With one

Table IV. Deaths and Case Fatality Rates

| YEAR | AGES | | | | | | | | | | TOTAL | |
|------------|-----------------------------------|-------------|----------|-------------|----------|-------------|------------|-------------|----------------|-------------|--------|-------------|
| | Under 1 yr. | | 1-4 yrs. | | 5-9 yrs. | | 10-14 yrs. | | 15 yrs. & over | | | |
| | Deaths | % Mortality | Deaths | % Mortality | Deaths | % Mortality | Deaths | % Mortality | Deaths | % Mortality | Deaths | % Mortality |
| 1950 | 1 | 8 | 0 | 0 | 2 | 2 | 0 | 0 | 5 | 6 | 8 | 2.4 |
| 1951 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1952 | 0 | 0 | 0 | 0 | 1 | 3 | 0 | 0 | 3 | 12 | 4 | 2.9 |
| 1953 | 0 | 0 | 1 | 1 | 3 | 4 | 3 | 9 | 6 | 9 | 13 | 5.1 |
| Total..... | Under 15: 11 deaths, 2% mortality | | | | | | | | 14 | 8 | 25 | 3.3 |

Table V. Disposition of Surviving Patients 1953

| | HOME | | ORTHOPEDIC HOSPITALS | |
|------------------------|------|----|----------------------|----|
| | No. | % | No. | % |
| Medical Service..... | 32 | 51 | 31 | 49 |
| Pediatric Service..... | 94 | 52 | 87 | 48 |
| Total | 126 | 52 | 118 | 48 |

exception, all the patients who died had either bulbar or bulbo-spinal involvement. The one exception had complete respiratory muscle paralysis without bulbar manifestations. The overall mortality for the four year period was 3.2%

Disposition of patients

Table V shows the disposition of surviving patients on both the Medical and Pediatric Services. Kernan's Hospital for Crippled Children and the Children's Hospital School received nearly all the patients who were not discharged home. All patients transferred in respirators were received at the Respirator Center of the Children's Hospital School.

Summary

During the past four years 761 patients with acute poliomyelitis were treated as in-patients at Baltimore City Hospitals. There have been marked fluctuations in annual case loads and variations in the proportion of case types. The overall mortality was 3.2%.

Commentary

The 1954 article on poliomyelitis is not *merely* of historical interest. It serves to emphasize not only how far we have come in control of infectious diseases, but, juxtaposed with the current human immunodeficiency virus (HIV) epidemic, how very far we have yet to travel. Poliomyelitis, like HIV-related disease, often strikes young, otherwise very healthy individuals. As physicians, we often have less difficulty caring for patients who are very aged or infirm in that it may truly seem according to the grand order of things, that it is "at or near their time." It is much more difficult to care for patients struck down with a devastating illness in their youth or in the prime of life. Certainly we cannot forget the image, either from personal experience, oral history, or photographic journals, of those huge rooms filled with polio patients in the coffin-like iron lungs.

In some respects, polio represented "the fear of the unknown." Early on, it was known only that a "filterable virus" was spread by oral-fecal contamination and that the spread might be facilitated in places where large numbers of people congregated. Mothers constrained their children from attending the local cinema or the local community swimming pool during times of epidemics. Nevertheless, a proven and fail-safe method to avoid infection was not available. In the HIV epidemic, we are more fortunate in that specific risk factors have

been clearly identified and largely quantitated, making HIV disease largely, if not almost completely, preventable. It is unfortunate that ignorance, poverty, addiction, sexual promiscuity, denial, and a general perception of the myth of "immortality" among youth have perpetuated and augmented the epidemic. Education of parents themselves, education of children by parents, discussion in schools and peer group formats are all instruments that seem never to have been prioritized at any level, including federal, local, and family. This must rank as one of the great tragedies and ironies of our time, especially in this era of over-development of communication. That which *is* communicated, especially by news media, is often frivolous or inappropriately prioritized.

Polio and HIV have both struck our famous national heroes. Although it is well known now, the majority of Americans were not aware of President Franklin D. Roosevelt's paralysis during the time of his administration and that he forbade pictures of himself in his wheelchair. By contrast, Magic Johnson and Arthur Ashe publicly announced their HIV status, hoping to influence young people to be more thoughtful and aware of risks.

As with poliovirus, not everyone exposed to HIV acquires the infection. Unlike poliovirus, however,

once HIV is acquired, the case fatality ratio appears to be 100%, often with an incredible burden of chronicity, expense, debility, and despair.

Although conventional RNA viruses like polio are not generally capable of inducing ongoing progressive disease (since they do not usually permanently affix themselves into the host DNA), the "post-polio syndrome" may be an exception. The ability of a young individual to adapt and compensate for permanently damaged tissue may be lost in the aging process and old dysfunctions, previously silent, may be unmasked. Thus polio, like HIV, may be responsible for progressive physiologic dysfunctions through time.

The development of an effective vaccine against poliovirus occurred only after cultivation of the virus within tissue culture systems so that the virus could be readily amplified, harvested, and inactivated. For many years, however, the problem seemed nearly insolvable. With the tissue culture system developed by Enders in 1949, and the killed virus vaccine introduced by Salk in 1953, specific prevention finally became available. Despite quantum leaps in scientific sophistication with HIV, however, the antigenic variability and inherent complexity of structure have been major stumbling blocks to the development of a vaccine. As in the case of poliovirus vaccine development, HIV vaccine development has initially focused almost exclusively on killed virus or subunit preparations. Concern about "back mutation" and inherent latent pathogenicity of a vaccine strain virus (which might not reach clinical expression until years later) have been of major concern. Even now, the occurrence of a polio-like illness in adults vaccinated with the oral preparation continues to occur at a very low level. Varicella-zoster vaccine, developed more than 10 years ago, is a live virus vaccine that has yet to be approved for general use in the United States, largely because of concerns about mutation to more virulent forms and latent oncogenicity.

Even today, poliovirus is still "alive and well" in many developing nations. The World Health Organization has made great strides, however, in mass vaccination programs in recent years. It is surprising that isolated clusters or mini-epidemics of poliomyelitis continue to occur (albeit infrequently), even in the United States. Several years ago, a tragic outbreak occurred in unvaccinated children in an Amish commu-

nity. Nevertheless, "herd immunity" by widespread immunization within the country, and by the general circulation of a vaccine-strain virus rather than wild-type virus, continues to amplify the effectiveness of the vaccine program itself.

Universal access to vaccination for all children is a current major priority and is finally being implemented, decades behind many western European nations. The expense of vaccination, at least partly driven by the profit motive within pharmaceutical companies and by built-in cost control for potential malpractice or maloccurrence defense, has escalated costs and made universal vaccination even more difficult to achieve. In this author's opinion, the government should champion the concept of "no-fault" awards to individuals who experience maloccurrence after vaccination. Such awards could be administered in an objective, efficient, unbiased, nonlitigation-based fashion.

As physicians, it is important for us to show concern and respect not only for the quantity of life for ourselves and our patients, but for the quality of such life as well. How can we improve the quality of life of those with HIV? How can we hope to improve the quality of life of human beings in general? Is this a medical, political, or social question? It is all of the above—and we as physicians need to prioritize this issue both in our individual practices and collectively through research and national organizations.

Although we know a great deal about preventive strategies of vaccination, how much do we really know and how well do we really teach and follow those outlooks and habits that foster a high quality of life (e.g., preventive medicine for a balanced life and mental health)?

How can we as physicians individually and politically help to ensure a better quality of life for the future? The so-called greying of America, the dissolution of family structures, the violence of the cities, and a general sense of purposelessness of life are very real psychosocial problems facing our country at this time. Let us become increasingly aware of these problems and help to solve them in innovative ways.

CHARLES A. HAILE, M.D.

Dr. Haile is chief of infectious diseases at Greater Baltimore Medical Center. ■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

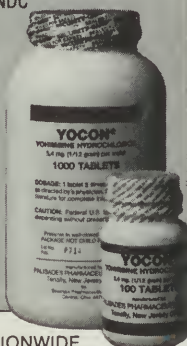
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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PRACTICE ISSUES

MEDICARE FRAUD ALERTS

- ❑ **To:** Medical & Chirurgical Faculty of Maryland
Maryland Group Managers Association
American Guild of Patient Account Management of the National Capitol Area
American Guild of Patient Account Management of Maryland
- ❑ **From:** Don Nicholson, Medicare Fraud and Abuse Information Coordinator
- ❑ **Date:** August 29, 1994
- ❑ **Subject:** Possible Over Utilization and Fraudulent Billing for Event Recorders
- ❑ **Copies:** Blue Cross Blue Shield of Maryland, Fraud Units
Health Care Financing Administration, Philadelphia Regional Office
Office of the Inspector General, Philadelphia Regional Office

Some physiological labs are allegedly billing Medicare for the use of event recorders for patients for whom the device was not prescribed or are allegedly guiding the beneficiary to abuse the monitor or may be billing for more tests than were actually taken. Also, some physicians may be receiving kickbacks as a result of routinely prescribing the monitors.

Examples of such problems are:

- A recorder being used to test multiple patients in the same facility within a short time period;
- Patients may be called by lab employees and told to test the monitor to ensure it is working properly and then billing Medicare for the test; or
- Patients may be instructed by lab employees to run the monitor at a predetermined time, whether they are experiencing the symptom or not.

This device has been billed under CPT code 93268: "patient demand single or multiple event recording with presymptom or postsymptom memory loop, includes transmission, physician review and interpretation, per 30 day period of time." High utilization by individual beneficiaries during a month or in consecutive months needs to be reviewed.

- ❑ **To:** Maryland Hospital Association
D.C. Hospital Association
Medical & Chirurgical Faculty of Maryland
Maryland Group Managers Association
American Guild of Patient Account Management of Maryland
American Guild of Patient Account Management of the National Capitol Area
- ❑ **From:** Don Nicholson, Medicare Fraud and Abuse Information Coordinator
- ❑ **Date:** August 30, 1994
- ❑ **Subject:** Screening Mammograms Billed as Diagnostic Mammograms
- ❑ **Copies:** Blue Cross Blue Shield of Maryland, Fraud Units
Health Care Financing Administration, Philadelphia Regional Office
Office of the Inspector General, Philadelphia Regional Office

Some hospitals are reportedly conducting screening mammograms but submitting claims for diagnostic mammograms. Diagnostic mammograms are reimbursed at higher rate and can be billed at a higher frequency than screening mammograms.

A screening mammography is allowable once every two years if the patient is over age 64. A screening mammogram is for an asymptomatic (without symptoms) patient, which includes patients with a family history of breast cancer. It does not require a physician's order. Screening mammograms should be billed under HCPCS code 76092 and revenue code 403. Payment is based upon a fee schedule amount. A diagnostic mammogram is allowable based upon medical necessity with no time restrictions on the frequency.

Medicare covers diagnostic mammograms *only* when ordered by a physician for the treatment or diagnosis of a patient's specific illness, symptom, complaint, or injury. Diagnostic mammograms should be billed under HCPCS code 76091 and revenue code 401, payment is based upon a fee schedule amount.

Questions regarding and responses to these Fraud Alerts should be directed to my attention at (410) 561-7976 or in my absence to Madge Greely at (410) 561-4134.

These alerts are provided for educational and informational purposes only. They are intended to assist parties in obtaining additional information concerning potential fraud and abuse and to alert affected parties to the nature of the suspected fraud. They are not intended to be used as a basis for the denial of claims or any adverse action against any provider or supplier. Such decisions must be based on facts developed independent of these alerts. These alerts are not intended to indicate, suggest or imply that any particular individual or entity, or group of individuals or entities, are associated with the activities described herein.

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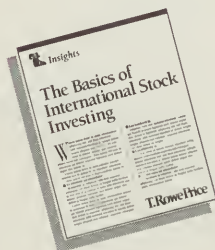
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In Memoriam

Raymond M. Curtis, M.D., one of the pioneers who developed the specialty of hand surgery during World War II and for whom the hand center at Union Memorial Hospital in Baltimore is named, died of prostate cancer October 9, 1994, at a nursing home in Mount Vernon, Washington state. Dr. Curtis, a native of Jefferson City, Missouri, received his medical degree from New York University College of Medicine in 1939, and completed his training in general surgery at Union Memorial Hospital in 1944. Stationed in California during his tour of active duty with the Army medical corps, he developed an interest in hand surgery and was made assistant chief of the hand service at McCornack General Hospital in Pasadena and later at Letterman General Hospital in San Francisco. He returned to Baltimore after the war to begin a private surgical practice with an emphasis on the then little-known subspecialty on which he was to become an authority. In 1971, he influenced the formation of the internationally known Hand Rehabilitation Center at Union Memorial, and in 1975 set up an emergency trauma unit at Union Memorial for upper extremity injuries as part of the Maryland Institute for Emergency Medical Services System. Dr. Curtis, who retired in 1982, was an associate professor in the departments of orthopedic and plastic surgery at The Johns Hopkins University School of Medicine. He was 80.

Frederick Graff, M.D., a retired ophthalmologist and long-time member of the Washington County Medical Society, died August 20, 1994, as a result of injuries he sustained in a fall at his home. Dr. Graff received his undergraduate degree from Marietta College in Ohio and his medical degree from the University of Maryland School of Medicine. During World War II, he was commander of the EENT service for the Seventh Evacuation Hospital in the South Pacific and participated in the invasion of Luzon, Philippine Islands. After completing a fellowship in ophthalmology, he entered private practice in Hagerstown in 1948, where he continued his medical practice until his retirement in the 1970s. Dr. Graff was buried with military honors.

Ernest Levi, M.D., a retired Baltimore psychiatrist, died at his home June 28, 1994, of a heart attack. Dr. Levi originally trained as a pharmacist at the University of Maryland School of Pharmacy, graduating in 1925. He received his medical degree from the University of Maryland School of Medicine in 1929 and practiced

internal medicine until 1950, when he decided to pursue the study of psychiatry. After training at The Johns Hopkins University School of Medicine, Veterans Hospital in Washington, DC, and the Seton Institute, he practiced psychiatry from 1953 until his retirement in 1990. A 40-year member of Med Chi, Dr. Levi was 89.

James M. Sowa, M.D., a rheumatologist with a special interest in lupus and arthritis, died at Saint Joseph Hospital in Towson, October 5, 1994, following a heart attack. Born in Michigan, Dr. Sowa completed his undergraduate work at Fordham University and earned his medical degree at the Downstate Medical Center College of Medicine of the State University of New York. He completed his internship and residency at City Hospitals in Baltimore and studied rheumatology at The Johns Hopkins Hospital. A founding fellow of the American College of Rheumatology, Dr. Sowa practiced at Greater Baltimore Medical Center and Children's, Good Samaritan, Saint Joseph, and Union Memorial hospitals. He was 56.

Mary Betty Stevens, M.D., a rheumatologist at The Johns Hopkins Hospital, professor of medicine at Hopkins medical school, and director of the department of rheumatology at Good Samaritan Hospital in Baltimore, died September 13, 1994, from complications of a stroke. A New York native who graduated from Vassar College in 1948, Dr. Stevens earned her medical degree at Hopkins in 1955. She subsequently conducted research on the possible links between rheumatic diseases, heredity, and the environment, and defined some of the genes that confer susceptibility to lupus. Considered a pioneer in the field, she was among the earliest physicians to use chemotherapy in the management of lupus, treatment that is now considered standard. In 1975, Dr. Stevens became the first woman to chair the department of rheumatology at Hopkins. She was a master in both the American College of Physicians and American College of Rheumatology, and the author of more than 100 published scientific papers. Dr. Stevens was 65.

No additional information was available at press time for the following members:

S. Charles Feldman, M.D.
Baltimore City

Eugene Kaplan, M.D.
Affiliate, May 6, 1994 ■

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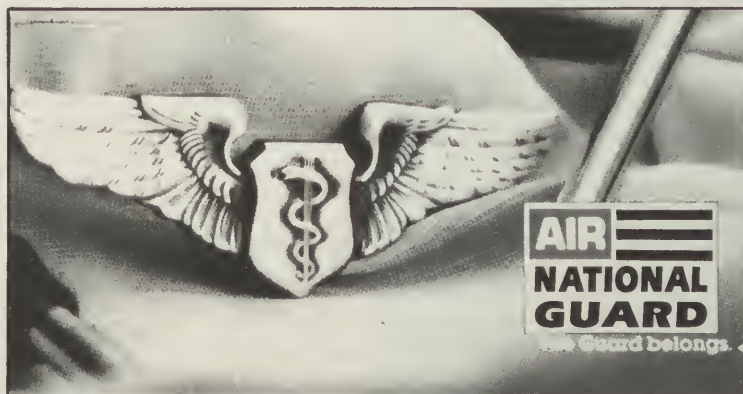


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ALLEGANY COUNTY

Dorothy Reiter served as the first treasurer of the Auxiliary to the Allegheny County Medical Society after it was organized in 1959. She has also served as recording secretary and vice president, as well as on numerous committees. A registered nurse, Mrs. Reiter is

the mother of seven, grandmother of 17, and great-grandmother of one. Her late husband, Ralph, was a pediatrician

ANNE ARUNDEL COUNTY

Joy Epstein's goals for the Anne Arundel County Alliance include service projects to enhance the health of the community, such as Sarah's House, a temporary shelter for mothers and children, and the Ballard Senior Center, which provides exercise programs and health topic speakers. Her husband, Michael, is a gastroenterologist. They have two children aged four and seven.



BALTIMORE CITY

Adriana Zarbin, who is also president of the Med Chi Alliance, has been an active participant in community and alliance activities for many years, including holding all leadership positions with the Baltimore City Alliance. She and her husband, Gino, a pediatrician, have three grown sons.



BALTIMORE COUNTY

Sharon Buckley, serving her second term as president of the Baltimore County Alliance, is the office manager for her husband, John, a psychiatrist. The mother of four, Mrs. Buckley hopes to continue to revitalize the alliance by working to increase membership.



CHARLES COUNTY

Karen Baig, serving her second term as president of the Charles County Alliance, plans to continue her component's efforts to recruit new members. Her husband, Khadar, is an internist and gastroenterologist. They have one son.



FREDERICK COUNTY

Patricia Brand plans to concentrate on increasing membership as well as community awareness of the alliance, particularly in its work on behalf of battered women and children. She and her husband, Steven, a general and vascular surgeon, have two children.



HARFORD COUNTY

Karen Carag, a registered nurse and CPR instructor, plans to work toward increasing her component's membership as well as helping to establish a domestic violence shelter in Harford County. The mother of two children and three stepchildren,

Mrs. Carag is married to Vicente, a general surgeon.



HOWARD COUNTY CONTACT PERSON

Helene Segal

KENT COUNTY

Elizabeth Donovan



MONTGOMERY COUNTY

Marcia Wolf plans to focus her component's energies on domestic violence education and prevention programs in schools and hospitals, as well as fundraisers to support projects such as health care for indigent children and the Foundation for Health Education. Her husband, Stanley, is an allergist.

PRINCE GEORGE'S COUNTY

Pat Bone's goals for her component include focusing on domestic violence, as well as continuing to support the mammography van for low-income women and the scholarship program for high school students planning a medical career. She and her husband, George, an internist, have three children.



WASHINGTON COUNTY

Linda Gray Jones, in addition to working toward increasing membership, plans to forge a closer relationship between her component and the Washington County Medical Society. Members will continue to support the scholarship fund, Organ Annie, and fund-raisers for the local chapter of Y-Me. A retail pharmacist, Mrs. Jones is married to Larry, a urologist.

WICOMICO COUNTY

Rebecca Allen plans a strong health education program for her component, including AIDS education in the public schools, Organ Annie and Smokey Sue. She also expects to diversify fund-raising activities. A deacon who teaches Sunday school and volunteers in her children's classes at school, Mrs. Allen is married to Robert, an internist. ■



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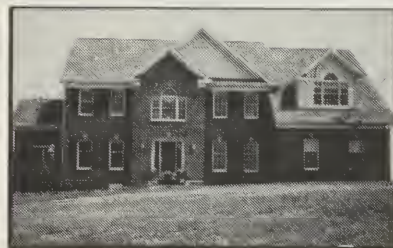
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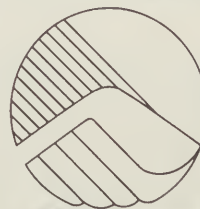
The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families.

The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201

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of Maryland



**Physician
Rehabilitation
Committee**

BLUECROSS BLUESHIELD OF MARYLAND
Minutes of the Carrier Advisory Committee (CAC) Meeting
September 21, 1994

The meeting was chaired by:

Barry S. Gold, M.D., Medical Director
 Joseph Berkow, M.D., Co-Chair

In attendance from the Maryland Medicare Contractor were the following:

Mary Anne Heckwolf, Vice President, Medicare Operations
 Helene Shugart, Director, Medicare Carrier Operations
 Elizabeth Krakowski, R.N., Medical Policy Coordinator
 Claudia Murray, Professional Relations
 Linda Watson, Professional Relations
 Sue Williams, Manager, Provider Operations
 Russ Bradley, Manager, Beneficiary Operations

In attendance from the Texas Contractor was the following:

Barbara Harvey, Director, Customer Support

In attendance from the Health Care Financing Administration (HCFA) were the following:

Carol Messick
 Joe Procopio
 Ted Gallagher

▼ **Welcome/Introduction**

The meeting was brought to order at approximately 6:30 p.m. Opening remarks were made by Dr. Berkow. Dr. Berkow welcomed the committee members and stated we had a full agenda of updates to the program as well as transition updates. He then introduced Claudia Murray, Professional Relations, to present the Medicare Program updates.

▼ **Medicare Program Updates**

Claudia Murray provided program updates which were included in the September, 1994 bulletin. Those items were as follows:

- ICD-9-CM Diagnosis Coding. Grace period will be 10/1 - 12/31/94 to accept both 1994 and 1995 codes. Effective 1/1/95, only 1995 codes will be accepted.
- 1994 Fee Schedules will be updated for 10/1/94. The 1995 Fee Schedule updates are on schedule.
- UPIN numbering is being expanded to special groups and limited license practitioners.
- Par Enrollment package will be mailed mid-November with a January 1 deadline for a response.

- Flu Vaccine procedures remain the same and are reimbursable by Medicare.

▼ **Medical Policy Updates**

Barry Gold, M.D., and Liz Krakowski, R.N., presented the medical policy updates:

- Collagen Implantation
- Myocardial Perfusion Imaging
- Paranasal Sinus CT Scans
- Routine Foot Care
- Penile Implantation
- Physical Therapy Payment for EMC & Nerve Conduction Studies

In addition, Dr. Gold discussed the following:

- Peripheral Blood Smears Interpretations

▼ **Transition Update**

Helene Shugart, Blue Cross and Blue Shield of Maryland, assured the committee that Maryland was dedicated to providing quality service until the end of the contract, 12/31/94. On a day to day basis, operations are monitored to assure service levels are met. Beneficiary and provider outreaches will continue through to the end of the contract. There will be one more bulletin in December which will address mandates. Maryland is supporting the activity necessary to make a smooth transition to Texas.

Barbara Harvey, from Blue Cross and Blue Shield of Texas, announced that the name for Medicare, effective 1/1/95, will be Trailblazer Health Enterprises, Inc. (T.H.E., Inc.). T.H.E., Inc. will be located in Hunt Valley, Maryland, and will provide a claims and service operations for the community. The Director of the Maryland Operations is David Vaughn, who comes from Travelers with many years of Medicare experience. It is T.H.E., Inc.'s intent not to impact the community so the Maryland medical policies will remain the same.

We are working with a Transition Consulting Team that is assisting us with input on ideas/concerns from the provider community.

▼ **Transition Consulting Team (TCT)**

Rose Matricciani, R.N., J.D., Chief Executive Officer of Med Chi, provided input on the complexion and direction of the TCT. The TCT is comprised of representatives of the

provider community to provide input of concerns the providers have expressed.

▼ *Future Carrier Advisory Committee*

Barry Gold, M.D., advised the group that due to circumstances of the transition, there was no need to discuss medical policy in December when the next meeting would be scheduled. It was agreed that the group would meet in December for a transition update.

▼ *The meeting adjourned at approximately 8:00 p.m.*
Respectfully submitted by:

Helene C. Shugart

Helene C. Shugart
Director, Medicare Carrier Operations



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The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

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All submissions should conform to requirements listed on the "Information for Authors" page of the *Maryland Medical Journal*. For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor, 1211 Cathedral Street, Baltimore, MD 21201; 410-539-0872 or 1-800-492-1056; FAX 410-547-0915.



The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.
The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.
In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.
- **Manuscript preparation**—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.
All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.
- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:
1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

• **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

• **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of

corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
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- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
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Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, Maryland 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

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|--|-------------------|
| Physician forum HIV: Substance abuse disorders in the HIV-infected patient—Management issues for the care provider , at the Brass Elephant Resturant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-4430. | Jan. 19 |
| Maryland Otolaryngology, Head & Neck Surgical Society: Evaluation & treatment of patients with chronic sinusitis , Baltimore, MD. 3 Cat 1 AMA credits, Fee: \$165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. | Feb. 21 |
| Physician Forum HIV: HIV care provision—medical, legal, and ethical dilemmas , at the Brass Elephant Resturant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-4430. | March 16 |
| MaryInd Otolaryngology, Head & Neck Surgical Society: Resident research presentations , at the Greater Baltimore Medical Center, Towson, MD. 3 Cat 1 AMA credits, Fee: \$165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. | April 25 |
| 8th Annual trauma anesthesia & critical care symposium , at the Hyatt Regency Hotel in Baltimore, MD. Cat 1 AMA credits. Info: Kimberly Unitas, 410-328-2399. | May 11–13 |
| Physician forum HIV: Beyond the recommendations—how we really care for AIDS patients , at the Brass Elephant Resturant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-4430. | May 18 |
| 21st Annual family medicine review course , at the Princess Royale Ocean Suite Hotel in Ocean City, MD. Cat 1 AMA/AAFP credits. Info: Althea Pusateri, 410-706-3956. | June 25–30 |

Miscellaneous meetings

- | | |
|--|--------------------|
| Cardiovascular conference at Snowshoe , sponsored by the American College of Cardiology, at the Mountain Lodge Conference Center, Snowshoe, WVA. 14.5 Cat 1 AMA credits. Info: 800-257-4739. | Feb. 6–8 |
| Fourth annual spring clinical nephrology meetings primary care nephrology program , sponsored by the National Kidney Foundation at the Sheraton Washington Hotel in Washington, DC. Info: 1-800-622-9010. | March 24-25 |
| Clinical perspectives on violence conference , at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: Professional Education Programs, 410-938-4598. | March 25 |
| Third world congress on stress, trauma and coping in the emergency services professions , at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311. | April 19–23 |
| Clinical innovations in OB/GYN ultrasound , sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine at the Lowes L'Enfant Plaza in Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by ACOB/GYN. Info: Ann Boehme 516-561-4223. | April 22–23 |

Miscellaneous meetings (continued)

Caring for the diabetic lower extremity: A practical approach for primary health care providers, sponsored by the American Diabetes Association at the Sheraton International Hotel, BWI Airport. 7 Cat 1 AMA credits. Fee: \$125/physicians; \$100/ACP members; \$75/other health professionals. Info: 410-526-2900. **April 28**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

"Tumor conference" **Dec. 8**

"Infectious disease topic" **Dec. 15**

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Seventh annual Wilmer Institute current concepts in ophthalmology, 20 Cat 1 AMA credits. **Dec. 10**

Memory and reality: Reconciliation. Scientific, clinical and legal issues of false memory syndrome, at the Stouffer Harborplace Hotel in Baltimore, MD. Cat 1 AMA credits available. Fee: \$400/professionals; \$275 families (includes 2 family members). **Dec. 9–11**

Basic comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. \$850/labs and lectures, \$325/lectures only. **Jan. 12**

Advanced comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. \$1400/labs and lectures; \$495/lectures only. **Jan. 13–14**

Advances in cardiac diagnosis and treatment 1995, at the Sheraton Baltimore North, Towson, MD. Cat 1 AMA credits available. Fee: TBA. **Jan. 19–20**

Frontiers in research and clinical management of asthma and allergy, 14 Cat 1 AMA/AAFP credits available. Fee: \$395/physicians; \$275/residents, fellows and allied health professionals. **Jan. 20–22**

Advances in cardiac diagnosis and treatment, 18 Cat 1 AMA credits. **Jan. 20–22**

1995 Update in the management of age-related macular degeneration, 8 Cat 1 AMA credits. Fee: \$225/physicians; \$125/residents, fellows and allied health professionals. **Jan. 21**

22nd Annual geriatrics symposium: Primary care for the practitioner, at the Stouffer Harborplace Hotel, Baltimore, MD. 18 Cat 1 AMA credits available. \$275. **Feb. 2–4**

12th Annual Houston Evertt memorial course in urogynecology, 17 Cat 1 AMA credits. **Feb. 24–25**

Pain treatment centers at a crossroads: A practical and conceptual reappraisal, 20 Cat 1 AMA credits. \$350/physicians; \$250/allied health professionals, residents, fellows. **March 3–5**

The Johns Hopkins Medical Institutions (continued)

| | |
|--|--------------------|
| Nuclear oncology , 16 Cat 1 AMA credits. Fee: \$495/physicians; \$395/residents, fellows, and allied health professionals. | March 8-10 |
| Principles and practice of clinical MRI , at the Renaissance Hotel, Washington, DC. 21.5 Cat 1 AMA credits. | March 23-26 |
| Fifth annual perspectives on clinical nutrition , 11 Cat 1 AMA credits. | March 24-25 |
| Spectrum of developmental disabilities XVII , 20 Cat 1 AMA credits. | March 27-29 |
| Diagnosis and treatment of neoplastic disorders , 13.5 Cat 1 AMA credits. \$300/advanced registration (prior to 2/1/95); \$325, registration; \$150/residents, fellows, and allied health professionals. | March 30-31 |
| 36th Annual postgraduate institute for pathologists in clinical cytopathology , 136 Cat 1 AMA credits. | Feb-March |
| Course A (Home Study) | April 3-14 |
| Course B (Johns Hopkins Medical Institutions) | April 1 |
| The care of patients with Alzheimer's and other dementias , at the Stouffer Harborplace Hotel, Baltimore, MD. 5.5 Cat 1 AMA credits available. Fee: \$120/physicians; \$75/residents, fellows, and allied health professionals. | April 3-8 |
| 23rd Annual pediatric trends , 42 Cat 1 AMA/AAP credits. \$650/physicians; \$450/residents and fellows. | April 6-7 |
| Clinical care of the patient with HIV infection , at the Stouffer Harborplace Hotel, Baltimore, MD. 13 Cat 1 AMA credits. | |



PHYSICIAN'S RECOGNITION AWARD

During October 1994, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Thomas A. Biondo, M.D.
Leonard D. Cutler, M.D.
Robert F. Draper, M.D.
Jasmine C. Gatti, M.D.
Antoine E. Kfuri, M.D.
George J. Lantos, M.D.
Sheldon R. Mandel, M.D.

Jowheri J. Mullick, M.D.
Jafar Nazemian, M.D.
Paul T. Noone, M.D.
Carlos J. Page, M.D.
Mark H. Pillor, M.D.
Harvey W. Rice, M.D.
Kenneth C. Rickler, M.D.

Donald W. Sample, M.D.
Moises N. Steren, M.D.
Robert C. Thompson, M.D.
William A. Warren, M.D.
Marcia D. Wolf, M.D.
Joseph I. Wollman, M.D.

The Johns Hopkins Medical Institutions (continued)

Current concepts in thyroid disease: Update 1995, 8.5 Cat 1 AMA credits. \$160/physicians; \$30/residents and fellows. **April 21**

Ninth annual mood disorders symposium, Cat 1 AMA credits pending. \$50/DRADA members; \$60/other. **April 25**

Wilmer nursing conference **April 28**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

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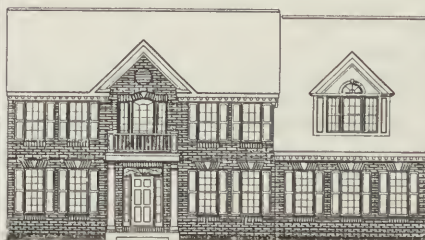


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December, 1994

New Vaccine Information Statements

New Vaccine Information Statements (VISs, also known as Vaccine Information Materials) have been approved to provide information about the benefits and risks of vaccines containing diphtheria, tetanus, pertussis, polio, measles, mumps, or rubella, to legal representatives of children or adults, who are being immunized with those vaccines. A set of all four VISs has been appended, after the Questions and Answers. The Questions and Answers are provided to address various issues raised by providers of vaccination services.

Vaccine Information Statements: Questions and Answers

1Q. Why are there new Vaccine Information Statements (VISs) for MMR, polio, DTP, and Td?

1A. The new statements are the result of an amendment to the National Childhood Vaccine Injury Act (NCVIA). The amendment was designed to simplify the vaccine information materials and the process by which they are developed and revised. The Department of Health and Human Services proposed legislation to amend section 2126 of the original law based on concerns expressed by providers and others about the length and readability of the Vaccine Information Pamphlets (VIPs), and the lengthy development and revision process required by the rule-making process. On December 14, 1993, the President signed into law the amendment, which: (1) deletes the requirement for development and revision of the VISs by rule-making;

(2) simplifies the information to be included in the materials; and (3) clarifies that the materials must not only be provided to the parent or legal representative of a child receiving a covered vaccine, but also must be provided to any *adult* who receives a covered vaccine.

The information requirements for materials to be given by health care providers to the legal representatives of any child or to any other individual receiving particular vaccines (*i.e.*, measles, mumps, rubella, poliomyelitis, diphtheria, tetanus, and pertussis vaccines) are now: (1) a concise description of the benefits of the vaccine; (2) a concise description of the risks associated with the vaccine; (3) a statement of the availability of the National Vaccine Injury Compensation Program; and (4) such other relevant information as may be determined by the Secretary.

2Q. Who has to use the new VISs, and when must they be in place?

2A. Beginning October 1, 1994, *all* public and private providers who administer the vaccines noted above are required to use the VISs developed by the Centers for Disease Control and Prevention (CDC). The NCVIA amendment *deleted* the language that allowed providers who buy their own vaccine the flexibility to develop their own materials. VIP's in use

prior to October 1, 1994, should be discarded when the new VISs are stocked.

3Q. How will the VISs be distributed?

3A. The Immunization Division of the Maryland Department of Health and Mental Hygiene (DHMH) will print and distribute VISs to public health clinics. Additionally, DHMH will distribute individual copies of each VIS to its mailing list of child health providers and internists. The VISs appearing in this issue of the Maryland Medical Journal may also be used for reproduction. Copies for reproduction may also be obtained by calling the Immunization Division at (410) 225-6679. Some private provider organizations plan to print and sell copies of the VISs.

4Q. Who is qualified under Maryland law to consent to immunization of a minor?

4A. Under Maryland law, the following individuals may consent to immunization of a minor:

- a. natural or adoptive parent;
- b. a guardian of a minor;
- c. any other person who, under court order, is authorized to give consent for the minor;

or, (1) when delegated by the parent verbally or in writing, or (2) if the minor's parent is not "reasonably available" and has not denied consent for the immunization:

- d. a grandparent;
- e. an adult brother or sister;
- f. an adult aunt or uncle;
- g. a stepparent; or
- h. any other adult who has care and control of the minor.

5Q. What happened to the signature blocks on the VISs?

5A. Health care providers are *not* required to obtain the signature of the patient, parent, or legal representative, acknowledging receipt

of the VISs, or the Important Information Statements (IISs) (currently available for *Haemophilus influenzae* type b [Hib] and hepatitis B). However, to ensure that a record of provision of the materials exists, health care providers must make a notation in each patient's permanent medical record at the time the VISs are provided. For providers who obtain vaccine via federal contract, including the Vaccines for Children [VFC] Program, the CDC Immunization Grant Guidance defines this as (1) date printed on the appropriate VIS or IIS and (2) date the VIS/IIS was given to the vaccine recipient or the parent or legal representative.

6Q. Are the VISs considered to be "informed consent"?

6A. "Informed consent" requirements are determined by state law. The VISs were written to fulfill the information requirements of the amendment to the NCVIA, and are not termed "informed consent" documents. However, because the materials cover both benefits and risks associated with vaccines, they provide enough information that anyone reading the materials should be adequately informed.

In Maryland, there is no state statute specifically requiring client signature for "informed consent". Health care providers should consult their legal counsel as to whether or not to obtain signatures of parents or others authorized to sign prior to immunizing.

7Q. Have other recordkeeping requirements changed?

7A. No. Besides making a notation in each patient's permanent medical record at the time the VISs are provided, health care providers who administer a vaccine must still record in each patient's permanent medical record, as required by the NCVIA, for each vaccine:

- (1) the date of administration of the vaccine;
- (2) the manufacturer and lot number of the vaccine; and
- (3) the name and address. . . " of the health care provider administering the vaccine . . . " (The address should be the address where the record is kept. If immunizations are given in a shopping mall, for example, the address would be the clinic where the permanent record will reside after the provider returns it to the clinic.)

8Q. Are the new VISs shorter and easier to read?

8A. Yes. Each VIS is an 8½" by 11" sheet, printed on both sides. Grade reading levels are 5th to 7th grade for the VISs compared to 8th grade for the older VIPs.

9Q. Have the requirements changed concerning when the materials are to be given?

9A. No. CDC interprets the language of the law ("each health-care provider . . . shall provide . . . a copy of the information materials . . .") to mean EVERY TIME a vaccine is administered.

10Q. What about statements for *Haemophilus influenzae* type b (Hib) and hepatitis B (hep B)?

10A. Within the year, the existing Important Information Statements (IISs) for Hib and hep B will be modified, so that they have the same format as the VISs. Because neither vaccine is currently covered by the National Vaccine Injury Compensation Program, providers who buy their own vaccines are not required to use them when administering privately-purchased vaccines. However, because of Duty to Warn clauses required by the manufacturers to be included in the federal contracts, all providers who administer doses of Hib or hep B purchased through the federal contracts

(including all Vaccines for Children Program vaccines) are required to provide the IISs prior to administration of those Hib and hep B vaccine doses.

11Q. What about a statement for use with the DTP/Hib combination vaccines?

11A. Use both the DTP VIS and the Hib IIS when giving a combination DTP/Hib vaccine until a new DTP/Hib VIS is developed.

12Q. What translations will be available for the VISs, and when will they be available?

12A. CDC will translate the VISs into Chinese, French, Spanish, and Vietnamese. These should be available before the end of 1994.

13Q. May immunization projects or other providers:

(a) use the existing translated Vaccine Information Pamphlets (VIPs - dated 10/15/91) until the VIS translations are available?

(b) translate the VISs into other languages (besides Chinese, French, Spanish, and Vietnamese)?

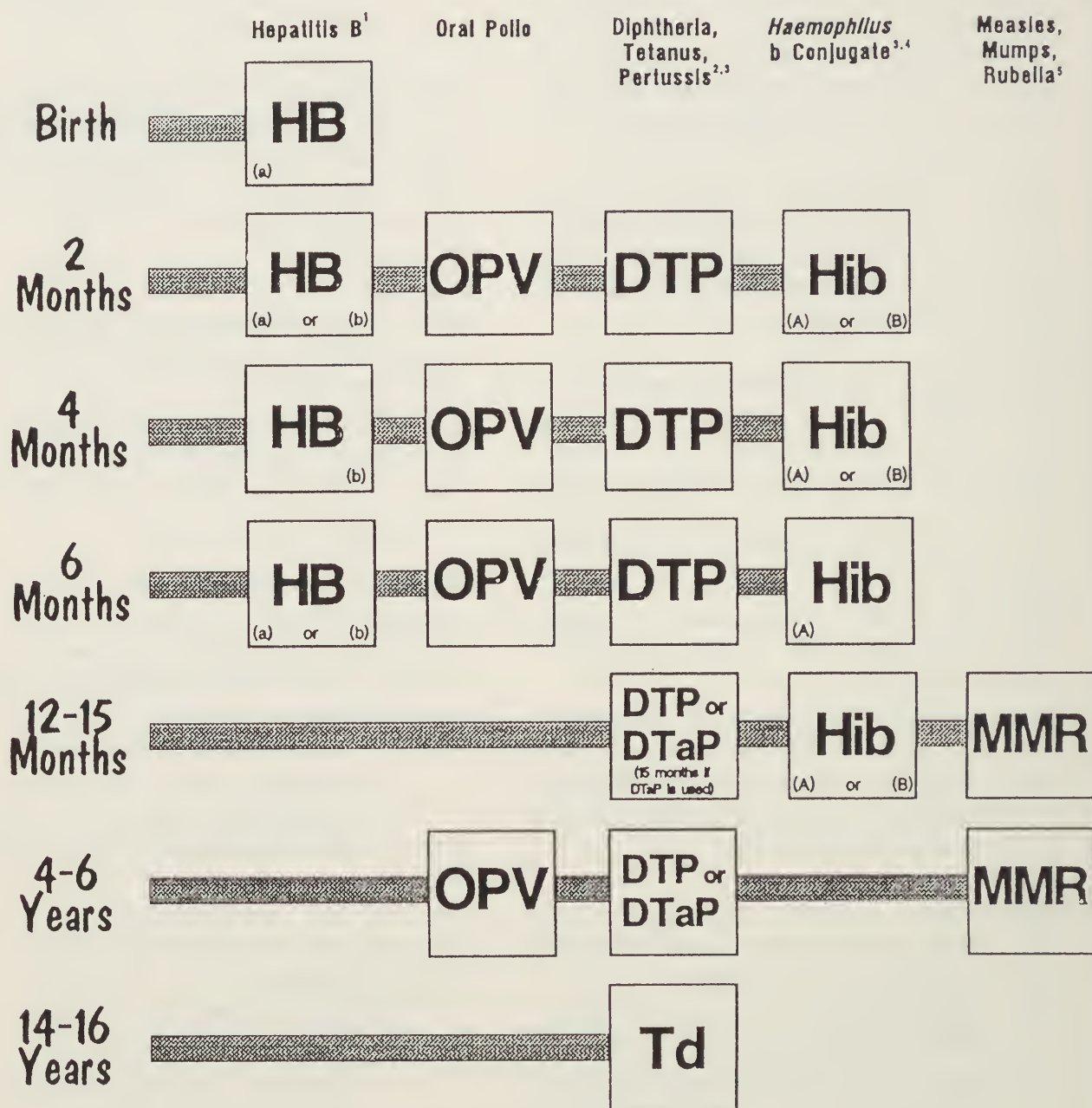
13A. (a) Yes, translated VIPs may be used until the VIS translations are available.

(b) Yes, projects or providers may translate the VISs into other languages. These do not have to be approved by CDC.

(Adapted from *Federal Register*, "New Vaccine Information Materials; Notice," [59 FR 31888], p. 31889, July 20, 1994 and Questions and Answers from the Centers for Disease Control and Prevention.)

ACIP Recommended Immunization Schedule

9/94



NOTE

- All recommended vaccines may be given simultaneously.
- These recommended ages are not absolute. For example, 2 months can be 6-10 weeks.

¹Hepatitis B vaccine may be given in either of 2 schedules:

- (a) Birth, 1-2 Months, 6-18 Months
- (b) 1-2 Months, 4 Months, 6-18 Months

²DTP preparation containing acellular pertussis vaccine (DTaP) is recommended for the 4th and 5th doses (for children 15 months of age or older), but whole-cell DTP may still be used if DTaP is not available.

³Combination DTP/Hib conjugate vaccine may be used when both shots are scheduled simultaneously.

⁴There are 2 schedules for Hib conjugate vaccines:

- (A) HbOC (HibTITER™), PRP-T (ActHIB™), or DTP/HbOC (TETRAMUNE™): 2, 4, 6, & 12-15 Months
- (B) PRP-OMP (PedvaxHIB®): 2, 4, & 12-15 Months

⁵The second dose of MMR may be administered at 11-13 years of age.

DIPHTHERIA, TETANUS, AND PERTUSSIS VACCINE (DTP)

What you need to know
before your child gets
the vaccine



ABOUT THE DISEASES

Diphtheria, tetanus (lockjaw), and pertussis (whooping cough) are serious diseases. Diphtheria and pertussis spread when germs pass

from an infected person to the nose or throat of others. Tetanus is caused by a germ that enters the body through a cut or wound.

| | | |
|---|--|---|
| <p>Diphtheria causes: a thick coating in the nose, throat, or airway</p> <p>It can lead to: - breathing problems - heart failure - paralysis - death</p> | <p>Tetanus causes: serious, painful spasms of all muscles</p> <p>It can lead to: - "locking" of the jaw so the patient cannot open his or her mouth or swallow - death</p> | <p>Pertussis causes: coughing and choking for several weeks (makes it hard for infants to eat, drink, or breathe)</p> <p>It can lead to: - pneumonia - seizures (jerking and staring spells) - brain damage - death</p> |
|---|--|---|

ABOUT THE VACCINES

Benefits of the vaccines

Vaccination is the best way to protect against diphtheria, tetanus, and pertussis. Because most children get the vaccines, there are now many fewer cases of these diseases. There would be many more cases if we stopped vaccinating children.

DTP schedule

Most children should have a total of 5 DTP vaccines. They should have DTP at:

- ✓ 2 months of age
- ✓ 4 months of age
- ✓ 6 months of age
- ✓ 12-18 months of age
- ✓ 4-6 years of age

Other vaccines may be given at the same time as DTP.

Related vaccines

DTaP (Diphtheria Tetanus acellular Pertussis)

- Like DTP, it prevents diphtheria, tetanus, and pertussis.
- It is only given for the 4th and 5th doses.
- It is less likely to cause the mild problems we see after DTP and is probably less likely to cause some of the moderate problems.

DT (Diphtheria Tetanus)

- Unlike DTP, it does not prevent pertussis. For this reason, it is usually not recommended.



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Who should get DTP vaccine?

Most doctors recommend that almost all young children get DTP or DTap vaccine. Some children should get DT. With all vaccines, there are some cautions.

Tell your doctor or nurse if the child getting the vaccine:

- ever had a serious allergic reaction or other problem after getting DTP, DTap, or DT
- now has moderate or severe illness
- has ever had a seizure
- has a parent, brother, or sister who has had seizures
- has a brain problem that is getting worse

If you are not sure, ask your doctor or nurse.

What are the risks from these vaccines?

As with any medicine, there are very small risks that serious problems, even death, could occur after getting a vaccine.

The risks from the vaccine are much smaller than the risks from the diseases if people stopped using vaccine.

Below is a list of problems that may occur after getting the vaccine. *If your child ever had one of the moderate or severe problems listed below or any other serious problem after DTP, DTap, or DT, discuss it with your doctor or nurse before this vaccination.*

Mild problems

If these problems occur, they usually start within hours to a day or two after vaccination. They usually last up to 1–2 days:

- soreness, redness, or swelling where the shot was given
- fever
- fussiness, drowsiness, less appetite

Acetaminophen or ibuprofen (non-aspirin) may be used to prevent or reduce fever and soreness. This is especially important for children who have had seizures or have a parent, brother, or sister who has had seizures.

Moderate problems

Once for every 100–1,000 doses:

- on-going crying for 3 hours or more
- fever of 105° or higher
- an unusual, high-pitched cry

Once for every 1,750 doses:

- a seizure (jerking and staring spell) usually caused by fever
- "shock-collapse" (becomes pale, limp, and less alert)

Severe problems

These problems happen **very rarely**:

- serious allergic reaction after DT or DTP
- a long seizure
- decreased consciousness or coma. Some of these children may have lasting brain damage. There is disagreement about whether or not DTP causes the lasting brain damage. If it does, it is very rare.

What to do if there is a serious reaction:

- ☎ Call a doctor or get the person to a doctor right away.
- ☎ Write down what happened and the date and time it happened.
- ☎ Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call:
(800) 822-7967 (toll-free)

The **National Vaccine Injury Compensation Program** gives compensation (payment) for persons thought to be injured by vaccines. For details call:
(800) 338-2382 (toll-free)

If you want to learn more, ask your doctor or nurse. She/he can give you the vaccine package insert or suggest other sources of information.

MEASLES, MUMPS, AND RUBELLA VACCINE (MMR)

What you need to know before you or your child gets the vaccine



ABOUT THE DISEASES

Measles, mumps, and rubella (German measles) are serious diseases. They spread when

germs pass from an infected person to the nose or throat of others.

| | | |
|--|---|---|
| <p>Measles causes: rash cough fever</p> <p>It can lead to: - ear infection - pneumonia - diarrhea - seizures (jerking and staring spells) - brain damage - death</p> | <p>Mumps causes: fever headache swollen glands under the jaw</p> <p>It can lead to: - hearing loss - meningitis (infection of brain and spinal cord coverings) - Males can have painful, swollen testicles.</p> | <p>Rubella causes: rash mild fever swollen glands arthritis (mostly in women)</p> <p>Pregnant women can lose their babies.</p> <p>Babies can be born with birth defects such as: - deafness - blindness - heart disease - brain damage - other serious problems</p> |
|--|---|---|

ABOUT THE VACCINES

Benefits of the vaccines

Vaccination is the best way to protect against measles, mumps, and rubella. Because most children get the MMR vaccines, there are now many fewer cases of these diseases. There would be many more cases if we stopped vaccinating children.

MMR schedule

Most children should have a total of 2 MMR vaccines. They should have MMR at:

- ✓ 12-15 months of age
- ✓ 4-6 years of age or before middle school or junior high school

Other vaccines may be given at the same time as MMR.

Who should get MMR vaccine?

Most doctors recommend that almost all young children get MMR vaccine. But there are some cautions. Tell your doctor or nurse if the person getting the vaccine is less able to fight serious infections because of:

- a disease she/he was born with
- treatment with drugs such as long-term steroids
- any kind of cancer
- cancer treatment with x-rays or drugs

Also:

- People with AIDS or HIV infection usually *should get* MMR vaccine.
- Pregnant women should wait until after pregnancy for MMR vaccine.



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- People with a serious allergy to eggs or the drug neomycin should tell the doctor or nurse. If you are not sure, ask the doctor or nurse.

Tell your doctor or nurse if the person getting the vaccine:

- ever had a serious allergic reaction or other problem after getting MMR
- now has moderate or severe illness
- has ever had a seizure
- has a parent, brother, or sister who has had seizures
- has gotten immune globulin or other blood products (such as a transfusion) during the past several months

If you are not sure, ask your doctor or nurse.

What are the risks from MMR vaccine?

As with any medicine, there are very small risks that serious problems, even death, could occur after taking a vaccine.

The risks from the vaccine are much smaller than the risks from the diseases if people stopped using vaccine.

Almost all people who get MMR have no problems from it.

Mild or moderate problems

- Soon after the vaccination, there may be soreness, redness, or swelling where the shot was given.
- 1-2 weeks after the **first** dose, there may be:
 - rash (5-15 out of every 100 doses)
 - fever of 103° or higher (5-15 out of every 100 doses). This usually lasts 1-2 days.
 - swelling of the glands in the cheeks, neck, or under the jaw
 - a seizure (jerking and staring spell) usually caused by fever. This is rare.
- 1-3 weeks after the **first** dose, there may be:
 - pain, stiffness, or swelling in one or more joints lasting up to 3 days (1 out of every 100 doses in children; up to 40 out of every 100 doses in young women). Rarely, pain or stiffness lasts a month or longer, or may come and go; this is most common in young and adult women.

Acetaminophen or ibuprofen (non-aspirin) may be used to reduce fever and soreness.

Severe problems

These problems happen **very rarely**:

- serious allergic reaction
- low number of platelets (a type of blood cell) that can lead to bleeding problems. This is almost always temporary.
- long seizures, decreased consciousness, or coma

Problems following MMR are much less common after the **second** dose.

What to do if there is a serious reaction:

- ☎ Call a doctor or get the person to a doctor right away.
- ☎ Write down what happened and the date and time it happened.
- ☎ Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call:
(800) 822-7967 (toll-free)

The **National Vaccine Injury Compensation Program** gives compensation (payment) for persons thought to be injured by vaccines. For details call:

(800) 338-2382 (toll-free)

If you want to learn more, ask your doctor or nurse. She/he can give you the vaccine package insert or suggest other sources of information.



POLIO VACCINE

What you need to know before you or your child gets the vaccine



ABOUT THE DISEASE

Polio is a serious disease. It spreads when germs pass from an infected person to the mouths of others. Polio can:

- paralyze a person (make arms and legs unable to move)
- cause death

ABOUT THE VACCINES

Benefits of the vaccines

Vaccination is the best way to protect against polio. Because most children get the polio vaccines, there are now very few cases of this disease. Before most children were vaccinated, there were thousands of cases of polio.

There are 2 kinds of polio vaccine

OPV or Oral Polio Vaccine is the one most often given to children. It is given by mouth as drops. It is easy to give and works well to stop the spread of polio.

IPV or Inactivated Polio Vaccine is given as a shot in the leg or arm.

OPV schedule

Most children should have a total of 4 OPV vaccines. They should have OPV at:

- ✓ 2 months of age
- ✓ 4 months of age
- ✓ 6-18 months of age
- ✓ 4-6 years of age

Other vaccines may be given at the same time as OPV.

Who should get OPV?

Most doctors recommend that almost all young children get OPV. But there are some cautions. Tell your doctor or nurse if the person getting the vaccine *or anyone else in close contact with the person getting the vaccine* is less able to fight serious infections because of:

- a disease she/he was born with
- treatment with drugs such as long-term steroids
- any kind of cancer
- cancer treatment with x-rays or drugs
- AIDS or HIV infection

If so, your doctor or nurse will probably give IPV instead of OPV.

If you are older than age 18 years, you usually do not need polio vaccine.

Travel

If you are traveling to a country where there is polio, you should get either OPV or IPV.

Pregnancy

If protection is needed during pregnancy, OPV or IPV can be used.

Allergy to neomycin or streptomycin

Does the person getting the vaccine have an allergy to the drugs neomycin or streptomycin? If so, she/he should get OPV, but not IPV. Ask your doctor or nurse if you are not sure.



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Tell your doctor or nurse if the person getting the vaccine:

- ever had a serious allergic reaction or other problem after getting polio vaccine
- now has moderate or severe illness

If you are not sure, ask your doctor or nurse.

What are the risks from polio vaccine?

As with any medicine, there are very small risks that serious problems, even death, could occur after getting a vaccine.

The risks from the vaccine are much smaller than the risks from the disease if people stopped using vaccine.

Almost all people who get polio vaccine have no problems from it.

Risks from OPV

Risks to the person taking OPV:

There is a very small chance of getting polio disease from the vaccine.

- about 1 case occurs for every 1½ million first doses
- about 1 case occurs for every 30 million later doses

Risks to people who never took polio vaccine who have close contact with the person taking OPV:

After a person gets OPV, it can be found in his or her mouth and stool. If you never took polio vaccine, there is a very small chance of getting polio disease from close contact with a child who got OPV in the past 30 days. (Examples of close contact include changing diapers or kissing.)

- about 1 case occurs for every 2 million first doses
- about 1 case occurs for every 15 million later doses

Talk to your doctor or nurse about getting IPV.

Risks from IPV

This vaccine is not known to cause problems except mild soreness where the shot is given.

What to do if there is a serious reaction:

- ☎ Call a doctor or get the person to a doctor right away.
- ☎ Write down what happened and the date and time it happened.
- ☎ Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call:
(800) 822-7967 (toll-free)

The **National Vaccine Injury Compensation Program** gives compensation (payment) to persons thought to be injured by vaccines. For details call:

(800) 338-2382 (toll-free)

If you want to learn more, ask your doctor or nurse. She/he can give you the vaccine package insert or suggest other sources of information.



TETANUS AND DIPHTHERIA VACCINE (Td)

What you need to
know before you or
your child gets the
vaccine



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ABOUT THE DISEASES

Tetanus (lockjaw) and diphtheria are serious diseases. Tetanus is caused by a germ that enters the body through

a cut or wound. Diphtheria spreads when germs pass from an infected person to the nose or throat of others.

Tetanus causes:

serious, painful spasms
of all muscles

It can lead to:

- "locking" of the jaw so
the patient cannot
open his or her mouth
or swallow

Diphtheria causes:

a thick coating in the
nose, throat, or airway

It can lead to:

- breathing problems
- heart failure
- paralysis
- death

ABOUT THE VACCINES

Benefits of the vaccines

Vaccination is the best way to protect against tetanus and diphtheria. Because of vaccination, there are many fewer cases of these diseases. Cases are rare in children because most get DTP (Diphtheria, Tetanus, and Pertussis), DTaP (Diphtheria, Tetanus, and acellular Pertussis), or DT (Diphtheria and Tetanus) vaccines. There would be many more cases if we stopped vaccinating people.

When should you get Td vaccine?

Td is made for people 7 years of age and older.

People who have not gotten at least 3 doses of any tetanus and diphtheria vaccine (DTP, DTaP, or DT) during their lifetime should do so using Td. After a person gets the third dose, a Td dose is needed every 10 years all through life.

Other vaccines may be given at the same time as Td.

Tell your doctor or nurse if the person getting the vaccine:

- ever had a serious allergic reaction or other problem with Td, or any other tetanus and diphtheria vaccine (DTP, DTaP, or DT)
- now has a moderate or severe illness
- is pregnant

If you are not sure, ask your doctor or nurse.

What are the risks from Td vaccine?

As with any medicine, there are very small risks that serious problems, even death, could occur after getting a vaccine.

The risks from the vaccine are much smaller than the risks from the diseases if people stopped using vaccine.

Almost all people who get Td have no problems from it.

Mild problems

If these problems occur, they usually start within hours to a day or two after vaccination. They may last 1-2 days:

- soreness, redness, or swelling where the shot was given

These problems can be worse in adults who get Td vaccine very often.

Acetaminophen or ibuprofen (non-aspirin) may be used to reduce soreness.

Severe problems

These problems happen **very rarely**:

- serious allergic reaction
- deep, aching pain and muscle wasting in upper arm(s). This starts 2 days to 4 weeks after the shot, and may last many months.

What to do if there is a serious reaction:

- ☞ Call a doctor or get the person to a doctor right away.
- ☞ Write down what happened and the date and time it happened.
- ☞ Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call:
(800) 822-7967 (toll-free)

The **National Vaccine Injury Compensation Program** gives compensation (payment) for persons thought to be injured by vaccines. For details call:

(800) 338-2382 (toll-free)

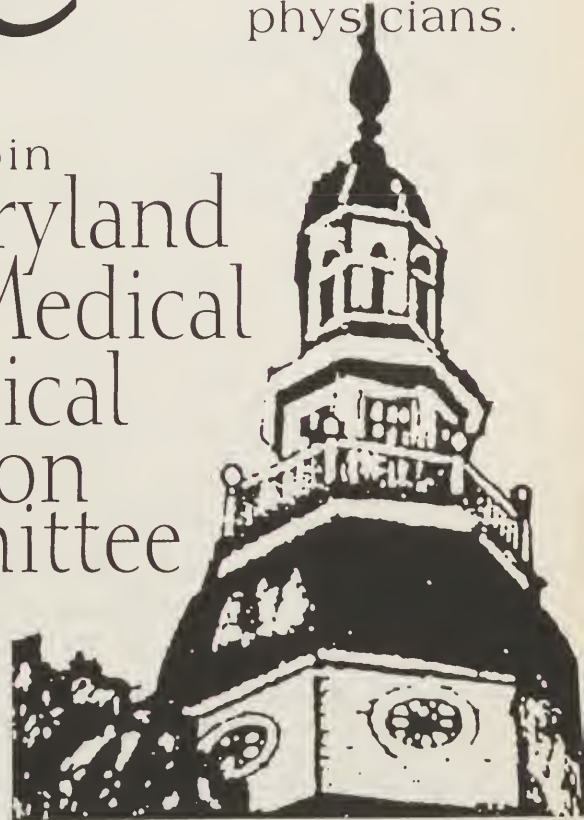
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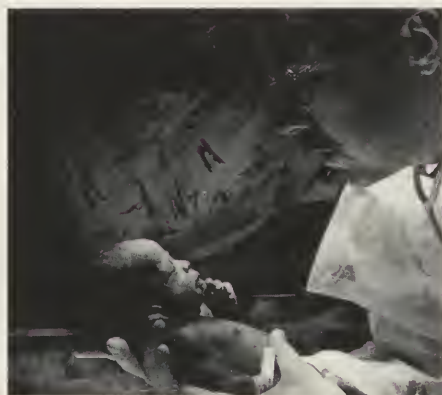
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A

Anthea N, Afroze M, Richard W. Is routine fecal occult blood testing worthwhile in hospitalized patients? 43(5):443-5, 1994 May.

Armstrong M Jr. Negligent sanitation practices in Baltimore barber shops. 43(2):131, 1994 Feb.

B

Bass-Feld ER. The use of art therapy in family violence. 43(4):361-3, 1994 Apr.

Bhushan C, Bhushan B. Health care cost and its containment: the dilemma of conflicting law, ethics and economics. 43(4):326-31, 1994 Apr.

Bhushan C, Herz DA. A plan for medical liability reform. 43(11):991-6, 1994 Nov.

Buckley JW. Physician education 43(7):565-6, 1994 July.

Burri M. Absinthe, Toulouse-Lautrec, and l'heure verte. 43(1):27-8, 1994 Jan.

C

Campbell JC. Child abuse and wife abuse: the connections. 43(4):349-50, 1994 Apr.

____ Domestic homicide: risk assessment and professional duty to warn. 43(10):885-9, 1994 Oct.

Cefalu CA. The 28-point mini-mental status examination. 43(5):431, 1994 May.

Ceraso M. Joseph Gagliardi, M.D.: revolutionary physician. 43(5):459-60, 1994 May.

Chung CK, Chung JS, Brace KC, et al. Radiotherapy for cancer of the larynx: review of a community hospital experience. 43(11):971-5, 1994 Nov.

Clark GL. Carpal tunnel syndrome surgery may harm patients' hands. 43(3):234, 1994 Mar.

Collier MT. The art of communicating with patients who use alcohol or other drugs. 43(1):18-21, 1994 Jan.

Cooper DS, Mersey JH. Postpartum thyroiditis. 43(5):463, 1994 May.

D

Daly MP, Lamy PP, Richardson JP. Avoiding polypharmacy and iatrogenesis in the nursing home. 43(2):139-44, 1994 Feb.

Davis T. BSAS commends *MMJ* initiative. 43(1):23, 1994 Jan.

DeHoff JB. Maryland medical license renewals, 1994: Continuing medical education requirements. 43(7):591-3, 1994 July.

____ Regarding the Uniformed Services University of the Health Sciences. 43(9):783, 1994 Sept.

DeLawter DE, Glover SE, Hall WG, et al. Changes in diabetes care during the past 50 years. 43(9):801-3, 1994 Sept.

DeVore PA. A computerized geriatric assessment designed for use in primary care physicians' offices. 43(3):257-64, 1994 Mar.

DeWeese J. Substance abuse in Maryland: what physicians can do to help. 43(1):29-33, 1994 Jan.

Diamond JR. The adverse effects of cholesterol in progressive glomerular injury. 43(5):451-5, 1994 May.

D'Lugoff BC. Where to refer patients who abuse alcohol or other drugs. 43(1):63-70, 1994 Jan.

Doherty RJ, Barish RA. The Chest Pain Evaluation Center at the University of Maryland Medical Center. 43(12):1047-52, 1994 Dec.

Drake JA. Physicians and attorneys: a partnership on behalf of the youngest victims of family violence. 43(4):365-7, 1994 Apr.

Dubowitz H. Medical neglect: what can physicians do? 43(4):337-41, 1994 Apr.

E

Elias EG, Brown SD, Buda BS, Honts SL. Breast cancer prevention trial. 43(3):249-52, 1994 Mar.

Emerick J. Church home and hospital: where caring is part of the cure. 43(3):243-7, 1994 Mar.

Epilepsy Association of Maryland, Inc. Guidelines for evaluation and management of people with seizures and epilepsy. 43(6):537-8, 1994 June.

Everton AR. New medical records copying charges effective October 1, 1994. 43(11):996, 1994 Nov.

F

Ferentz KS, Valente CM. Helping patients stop smoking. 43(1):45-9, 1994 Jan.

Fishbein RH. The Baltimore City Medical Society Foundation. 43(6):531-2, 1994 June.

Friedman A. Regarding "A moment with endocrinology and metabolism" *Maryland Medical Journal* November 1993. 43(4):333-4, 1994 Apr.

Friedman NS. Hypercalcemia associated with an elevated 1,25 dihydroxy vitamin D₃ level and an elevated angiotensin-converting enzyme level in a patient without evidence of sarcoidosis or malignancy. 43(5):439-42, 1994 May.

Friedman NS, Freedman MD. Correlation of DNA flow cytometry and hormone receptors with axillary lymph node status in patients with carcinoma of the breast. 43(11):963-5, 1994 Nov.

G

Gamponia MJ, Joines RW, Beilenson PL, et al. Cancer mortality in Maryland: when being a leader is not best. 43(11):957-61, 1994 Nov.

Gary NE. Ten components for reshaping medical education. 43(7):581-3, 1994 July.

Gershen BJ. Dr. Gershen replies. 43(9):782, 1994 Sept.
 ___ Lies, damned lies, and statistics. 43(5):426-8, 1994 May.
 ___ The numbers game. 43(9):815-7, 1994 Sept.
 ___ "Maryland! My Maryland!" 43(3):275-7, 1994 Mar.
 ___ Radicals. 43(5):465-6, 1994 May.

Gloth FM. Hospice: The most important thing you didn't learn in medical school. 43(6):511-3, 1994 June.

Grissler BG, Libre EP. Suburban Hospital: 50 years of service to the community. 43(9):785-6, 1994 Sept.

Gudwin AL, Padussis CJ. Smoking, age, and sex in carotid artery atherosclerosis: a review of 3,865 carotid duplex scans. 43(3):265-8, 1994 Mar.

H

Harman S. Med Chi library moving toward the year 2000: online information sharing is the key. 43(2):177-8, 1994 Feb.

Harris BA. Fitting the treatment to the problem: deciding where to refer substance abusers. 43(1):59-62, 1994 Jan.

Heldrich FJ. Selecting the appropriate method and time for a hearing impairment screen: is the NIH consensus statement premature? 43(2):171-3, 1994 Feb.

Hookman P. Sir William Osler and the current trajectory of medical education and health care at American academic health centers. 43(7):569-73, 1994 July.

Hrehorovich VR, Seaby RM. Nancy E. Gary, M.D.: Dean, F. Edward Hébert School of Medicine, Uniformed Services University of the Health Sciences. 43(6):501-4, 1994 June.

Hsu JKW, Heller JA, de la Cruz Z, Green WR. Secondary epiretinal membrane after blunt trauma. 43(6):505-8, 1994 June.

J

Jensen CE. Kent County's name a matter of timing. 43(9):782, 1994 Sept.

Johns MME. The status of medical education. 43(7):585-6, 1994 July.

Jolbitado, DL. Accreditation of continuing medical education programs in Maryland. 43(7):595-8, 1994 July.

Jones SM. Medical information giveaways. 43(6):527-8, 1994 June.

Jung PI, Nahas JN, Strickland GT, McCarter R, Israel E. Maryland physicians' survey on Lyme disease. 43(5):447-50, 1994 May.

K

Kalish M. The emergency medical services board and the reorganization of the Maryland Institute for Emergency Medical Services System. 43(12):1057-60, 1994 Dec.

Kanarek N. Lifestyle and chronic disease. 43(1):103-6, 1994 Jan.

Kennedy CP. Fifteen things you should know about new Maryland laws when making health care decisions. 43(3):253-6, 1994 Mar.

Klebaner M. Tobacco kills. 43(3):239, 1994 Mar.

Kowalewski EJ and Teter CH. Focused professional education. 43(7):599-600, 1994 July.

Krefting I, Nunez A, Sherer P, et al. Pleomorphic carcinoma (spindle and giant cell) of the lung. 43(9):787-90, 1994 Sept.

L

Libre EP and Cahan JJ. Continuing medical education at Suburban Hospital: past, present, and future. 43(9):805-6, 1994 Sept.

Lindsay JM, Greenough WB 3rd, Zelesnick LB, Kuhn KE. Fever in the nursing home resident. 43(2):159-64, 1994 Feb.

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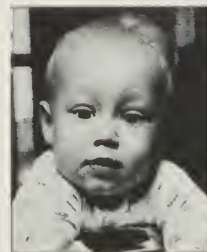
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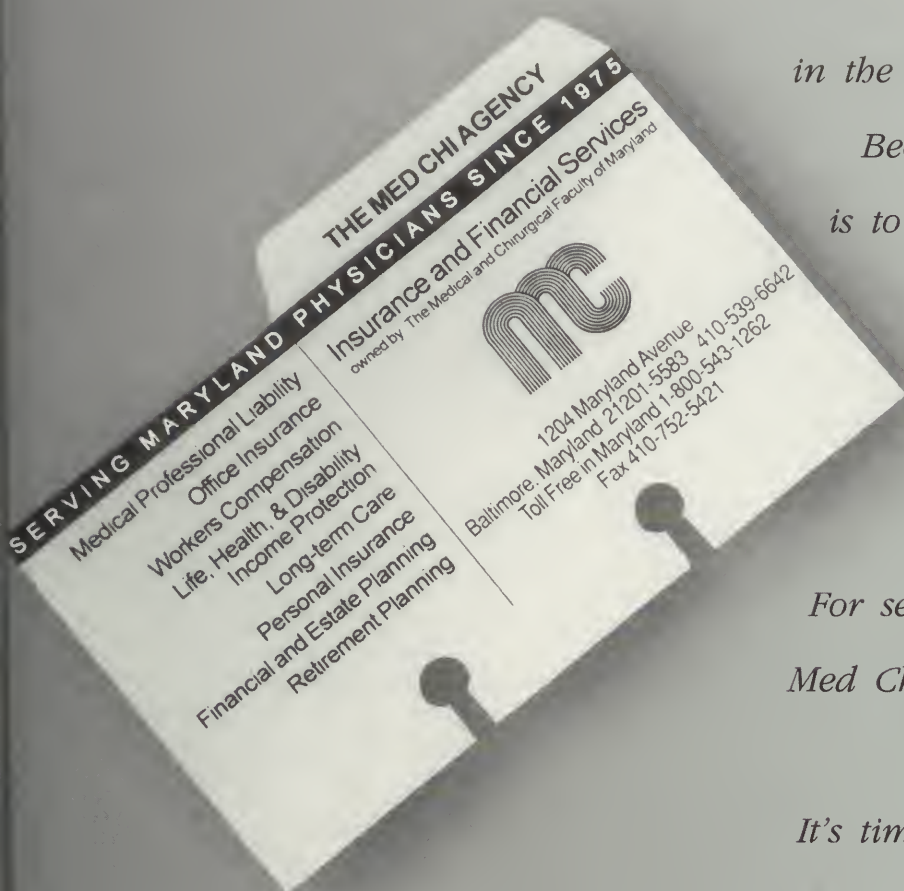
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